WASHINGTON STATE

PIHP EXTERNAL QUALITY REVIEW

REPORT 2004

CMS REPORTS

REVIEWERS
Wayne L. Neff, PhD., Executive Director
Brad Babayan, Information Services Reviewer
Cindy Britt, Administrative Manager
Marty Driggs, LMHC, NCC, Clinical/Administrative Reviewer

EXTERNAL QUALITY REVIEW
INTRODUCTION

The review of the 14 Prepaid Inpatient Health Plans (PIHPs) began with the External Quality Review Organization's (EQRO) pre-onsite activities. These activities consisted of the collection of the pre-onsite documentation which included the PIHP's location, organizational chart, names of Providers and contractors, and review of the completed Information Systems Capability Assessment (ISCA) form. Communications were made to answer questions, coordinate scheduling of staff and Provider interviews plus completion of the onsite review agenda.

The onsite reviews began with the first PIHP on July 26, 2004. On October 27th 2004 the last PIHP was completed. The APS EQRO onsite review team consisted of the Executive Director, Administrative Manager, Information Systems Reviewer, and the Clinical/Administrative Reviewer. We began the onsite reviews with an introductory meeting with the leadership staff of each PIHP. During this initial meeting, we started with introductions of the PIHP staff and the APS EQRO team. We then reviewed the agenda for the onsite review and discussed logistics for the review. The PIHP was asked to provide an overview of the organization, the intake assessment process, utilization review mechanisms, authorization of services, and progress on collecting core performance indicators. We then asked the PIHP to instruct the review team on the documents to be reviewed and how they were organized to create a road map to serve as a reference for the reviewers.

APS reviewers then conducted a review of the documents provided by the PIHP. Each reviewer was assigned specific areas to cover in the review, and read through the documents to determine the PIHP's compliance in each of the following areas:

- Performance Improvement Programs
- Performance Measures
- Utilization Management
- Medical Director, Case Management and Care Coordination
- Information Systems
- Provider and Contractor Services
- Enrollee Rights and Protections
- Grievance System
- Certifications and Program Integrity

The PIHP was asked to present scenarios, describing how services were delivered to clients, linkages to services, and outcomes achieved. Each reviewer recorded information in our Documentation and Reporting Tools that assisted in making a determination about compliance with each of the regulatory provisions. This documentation was then utilized to create the draft report based on the

Centers for Medicare and Medicaid Services (CMS) guidelines for compliance review.

In addition to the review of the Subparts and Performance Measures, APS has also conducted onsite reviews to verify the information submitted by each PIHP on their Information System Capability Assessment (ISCA) tool. The ISCA review has consisted of additional interviews of the applicable PIHP staff in order to clarify any vague or incomplete answers submitted on the ISCA tool. Following this the APS Information Systems Reviewer did onsite verification of the PIHP and Providers physical facilities which house the Information Technology (IT) servers and other hardware.

In general, the information obtained form the ISCA review was utilized to answer relevant questions on the Subparts, the Performance Measures, and the Performance Improvement Project reviews.

Once the onsite review was completed the PIHP was given ten (10) working days to submit any additional documentation they were unable to produce and/or additional documentation requested by the reviewers at the time of the onsite review. Once all of the documentation was received a report was drafted by each reviewer resulting in three (3) categories: The Subpart Review, the ISCA Review, and the Performance Measure Review.

The draft report was delivered to each of the PIHPs within approximately thirty (30) working days from the last date of their onsite review. Draft reports included a written assessment of evidence provided and interviews conducted during the onsite review, as well as scores based on the written assessment. The EQRO used the scoring guidelines provided by the Washington State Mental Health Division (MHD). The PIHP was then given a chance to review the report and submit any rebuttal or additional evidence they felt was undiscovered during the onsite review. Rebuttal and or additional documentation received from each of the PIHPS were reviewed by the EQRO and scores were adjusted according to the relevance of the additional documentation. The EQRO Executive Director then conducted a final debriefing with each PIHP Administrator to explain any changes that would be made to the original draft.

Following the External Quality Review of Washington State's fourteen (14) Prepaid Inpatient Health Plans (PIHPs), the Information Systems Reviewer reviewed both the MHD computer system that collects, maintains and transmits the PIHPs data to CMS; and the system used to calculate the performance measures used by MHD and the PIHPs State-wide. A similar review process as used at the PIHPs was employed for these reviews. Both groups were asked to fill out the Appendix Z ISCA tool and questions raised by those responses were followed up on. Interviews were conducted when necessary and client information was collected from the MHD system to compare with the client

information collected from the field. The results of these reviews are attached to the ISCA Summary Report and in the Performance Measures Report.

Attached you will find the final report that is being presented to CMS. It is tabbed into five sections that include the Introduction, Graphs and Charting of the Scores, the Subparts Report, the ISCA Report, and the Performance Measures Report.

STATISTICAL OVERVIEW AND GRAPHS

The following section includes data summaries, tables, graphs, and charts of the data collected during the onsite reviews and subsequent post onsite interactions with the PIHPs. In general the graphical information is arranged starting with higher level reviews followed by representations that include increasing details.

In some ways the data collection instrument was unique and as a result the review of the data should be undertaken with the following considerations;

- The data collection tool utilizes a six (6) point scale as opposed to a more common five (5) point scale. As a result there is no mid point in the scale.

- The most common scales used in social sciences is a five (5) point Likert scale with a low score of one(1) and a high score of five (5) with a mid point of three (3). With a five (5) point Likert scale scores of four (4) and five (5) are generally interpreted as positive and scores of one(1) and two (2) are seen as negative, where a three (3) is considered a neutral or average score. Since the midpoint on a six (6) point scale from 0-5 is actually 2.5 there is no midpoint or neutral score. As such scores of three (3) or above should be interpreted as slightly positive to very positive while scores of two (2) or below are slightly negative to very negative.

- When looking at averages or means it is important to remember that 2.5 is the statistical middle instead of 3.0.

- A final note of caution is that unlike a Likert scale which is generally validated to have equal intervals between scores. The scale used in this review may not have equal intervals between each of the scores. That is to say that the perceived difference between a zero (0) and a one (1) in our scale may not be equal to the perceived difference between a one (1) and a two (2).

DESCRIPTION OF STATISTICAL VISUALS & TABLES

Visual 1

The table represents descriptive statistics for all reviewed items for each PIHP. The table along with the graphic depicts the variation between the PIHPs as well as the variation within.

Visual 2

This chart represents a comparison between the performances of each PIHP as determined by the current external quality review. This chart helps to display graphically one of the key areas of opportunity for the State which is to improve utilization management control so that penetration and utilization is more consistent across the state. An important observation here is that even the highest penetration rates reported for Timberlands is significantly lower than national trends observed by the EQRO. Although this should be a point of concern, the low penetration rates may actually be due to data issues identified in the ISCA portion of this review, such as under reporting of encounter data and inability to collect and utilize member months in the calculation of the denominator.

It should also be noted that because of the transition to HIPAA compliant transaction reporting (including associated software implementations) during 2004, and attempts by the PIHPs to ensure complete and accurate data is in place for the actuary study, the PIHPs encounter data has been delayed and inconsistent during the period reviewed by the EQRO as PIHPs correct and resubmit their encounter data. As a result of the EQRO's review and feedback, MHD reported they are currently investigating the source of under reporting observed by the EQRO.

Visual 3

This chart allows comparison of the distribution of scores for each PIHP as well as comparison to the overall distribution of score. Each line is essentially a pie chart converted into columns. Each of the PIHPs has an individual pie chart with their distribution in the following visuals.

Visual 4

This is a pie chart of the distribution of scores statewide. Of note is that the percent of zeros (0s), ones (1s), and twos (2s) is equal to the percent of threes (3s), fours (4s), and fives (5s). Also a full fifty-seven percent (57%) of all scores fall into the mid range of twos (2's) and threes (3's).

Visual 5-18

Pie charts of this distribution of scores for each PIHP.

Visual 19

This is a chart displaying the average score for each PIHP across all subparts and PM scores.

Visual 20

This bar chart represents the mean of each score in Subpart C-Enrollee Rights and Protections for each PIHP.

Visual 21

This bar chart represents the mean of each score in Subpart D-Quality Assessment and Performance Improvement for each PIHP.

Visual 22

This bar chart represents the mean of each score in Subpart F-Grievance System for each PIHP.

Visual 23

This bar chart represents the mean of each score in Subpart H-Certifications and Program Integrity for each PIHP.

Visual 24

This bar chart represents the mean of each score in the Performance Measures for each PIHP.

Visual 25

This chart is based on the data evaluation done on the records supplied by the PIHPs and matched to data from the MHD-CIS system. It represents the average number of days to submit encounters by PIHP and the longest time recorded to submit encounters in days. A red line is at ninety (90) days indicating a target submission that would be acceptable. Considering that an encounter should be submitted within sixty (60) days of the close of the month the service was given in, thirty (30) days was added to account for the opportunity to correct errors for a target of ninety (90) days.

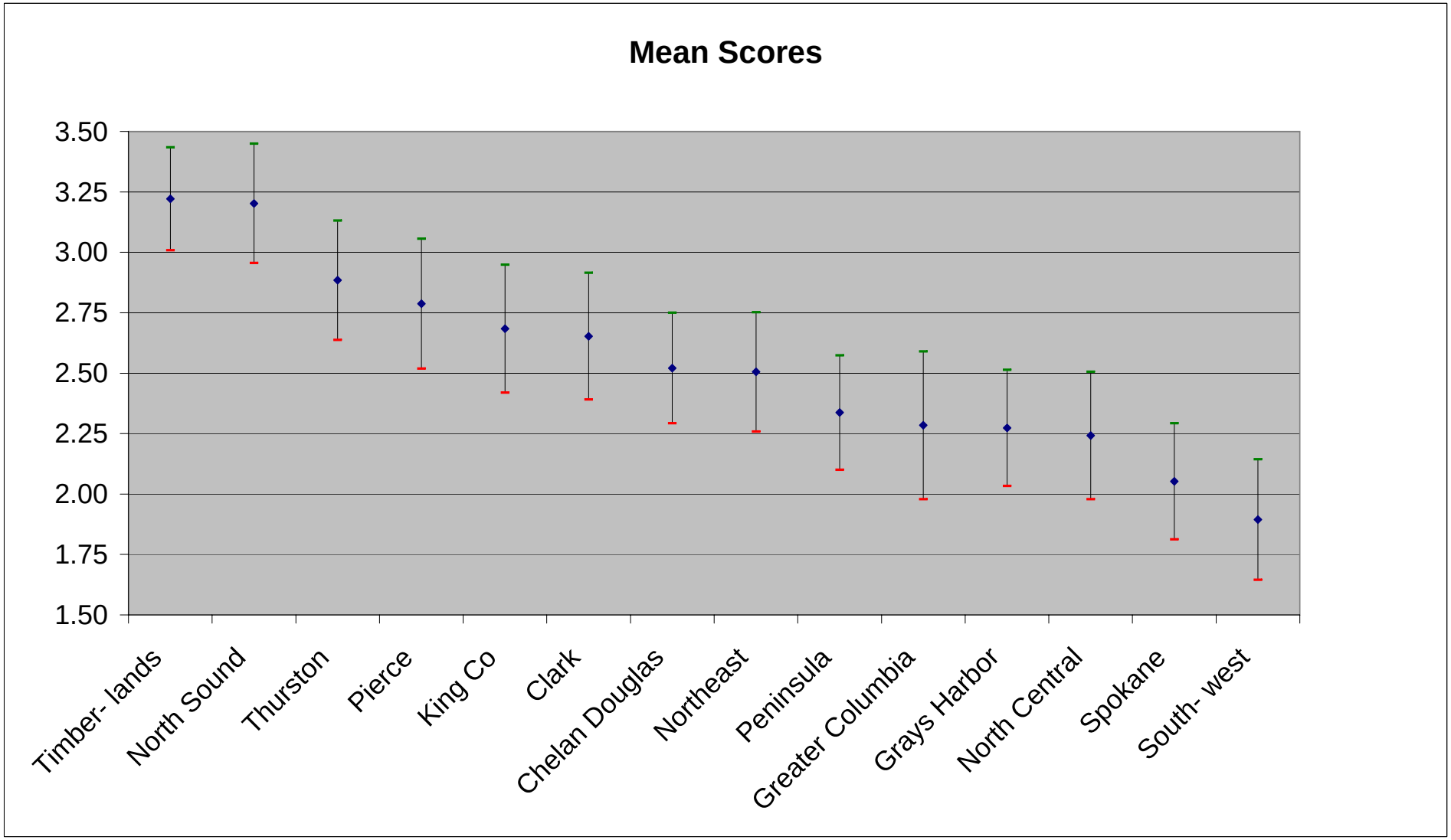
It should also be noted that because of the transition to HIPAA compliant transaction reporting (including associated software implementations) during 2004, and attempts by the PIHPs to ensure complete and accurate data is in place for the actuary study, the PIHPs encounter data has been delayed and inconsistent during the period reviewed by the EQRO as PIHPs correct and resubmit their encounter data.

Table 1

This table displays the average score and other simple statistics for each item in the review.

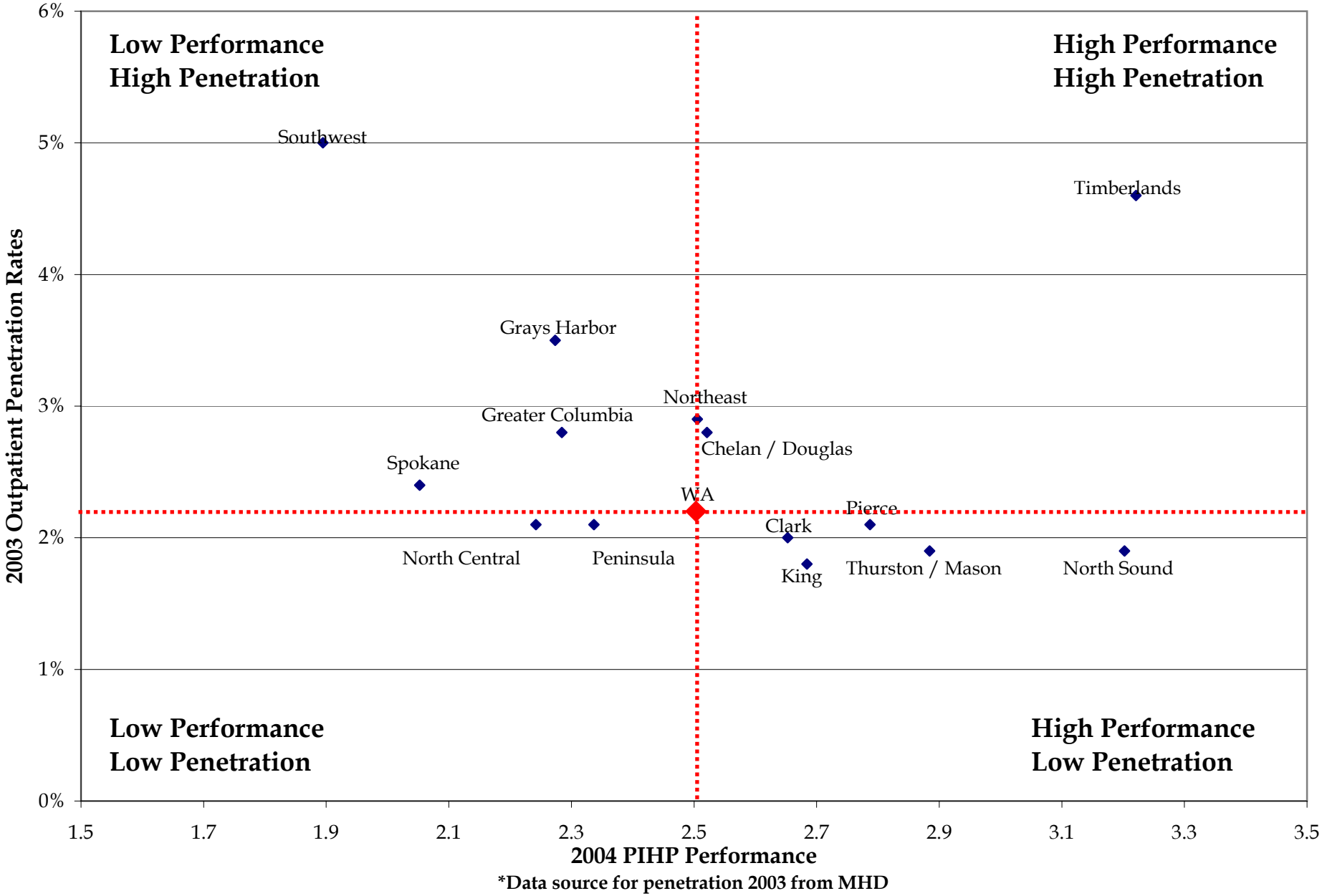
Visual 1

	Timber-lands	North Sound	Thurston	Pierce	King Co	Clark	Chelan Douglas	Northeast	Peninsula	Greater Columbia	Grays Harbor	North Central	Spokane	South-west
MEAN	3.22	3.20	2.88	2.79	2.68	2.65	2.52	2.51	2.34	2.28	2.27	2.24	2.05	1.89
MEDIAN	3	3	3	3	3	3	2	3	2	2	2	2	2	2
MODE	3	4	3	3	3	2	2	3	2	1	2	2	2	2
LCLM 95%	3.01	2.96	2.64	2.52	2.42	2.39	2.29	2.26	2.10	1.98	2.03	1.98	1.81	1.65
UCLM 95%	3.43	3.45	3.13	3.06	2.95	2.91	2.75	2.75	2.57	2.59	2.51	2.51	2.29	2.14
STD	1.04	1.21	1.21	1.31	1.30	1.29	1.11	1.21	1.16	1.50	1.18	1.29	1.18	1.22
N	95	94	95	94	95	95	94	95	95	95	95	95	95	95



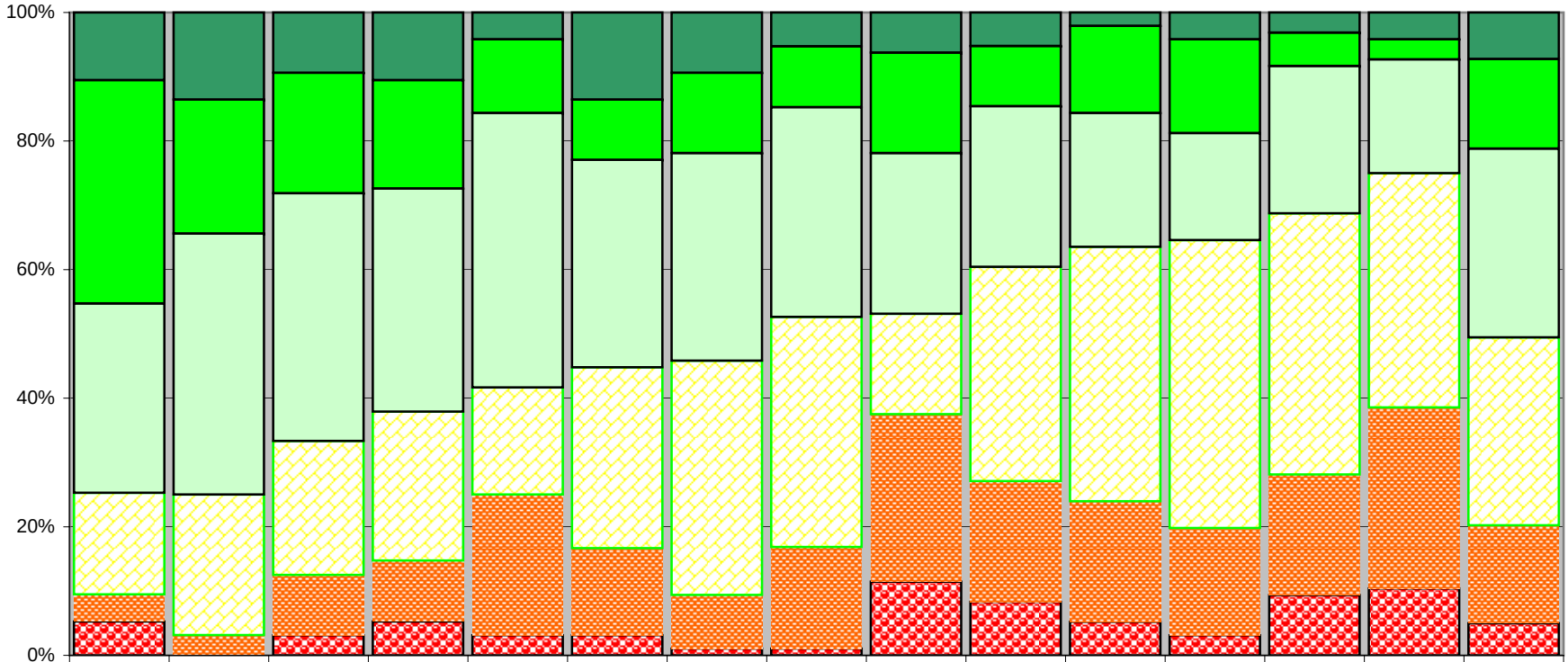
Visual 2

A Comparison of Performance Vs. Outpatient Penetration Rates by PIHP



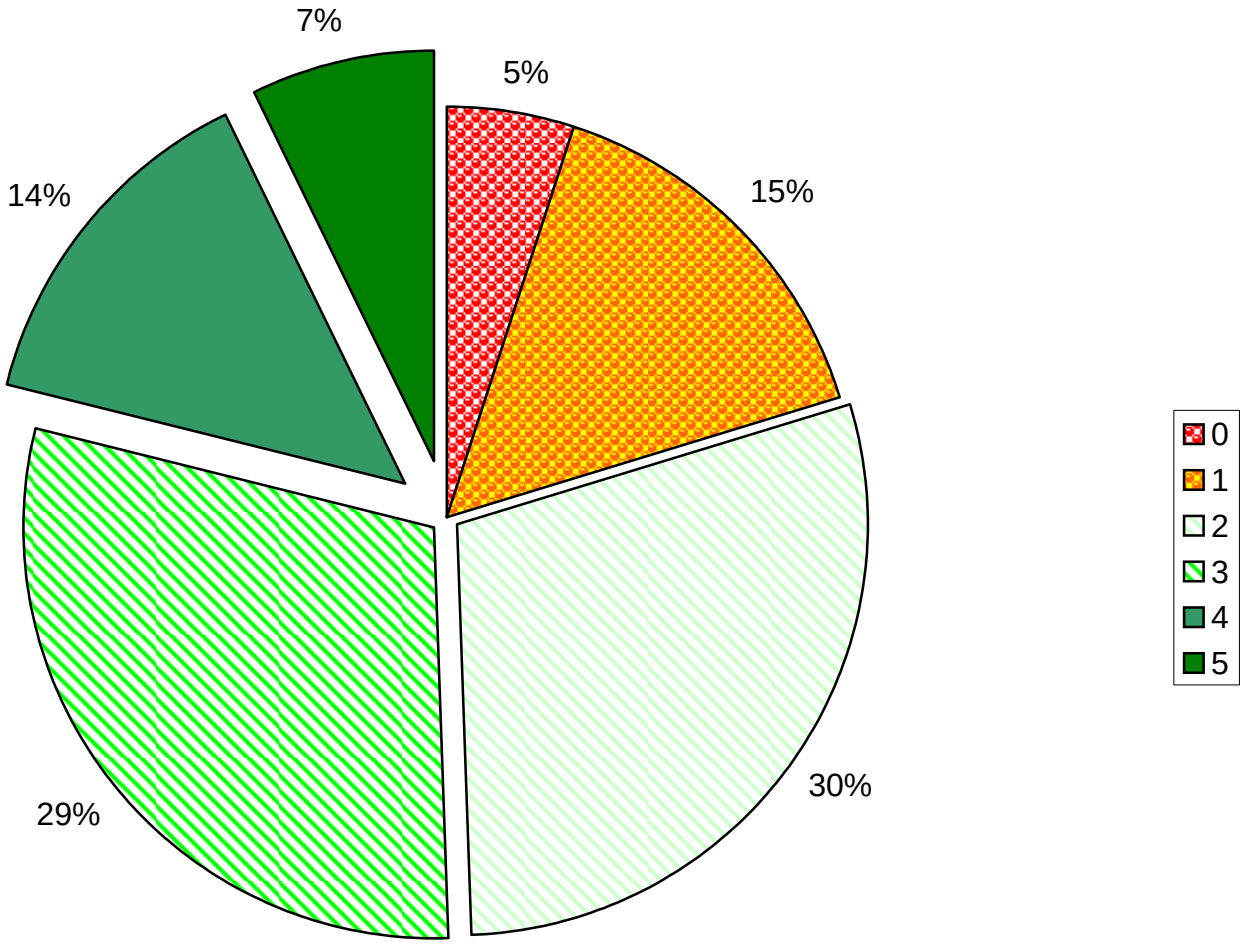
*Data source for penetration 2003 from MHD

Visual 3
Overall Disitribution of Scores by PIHP

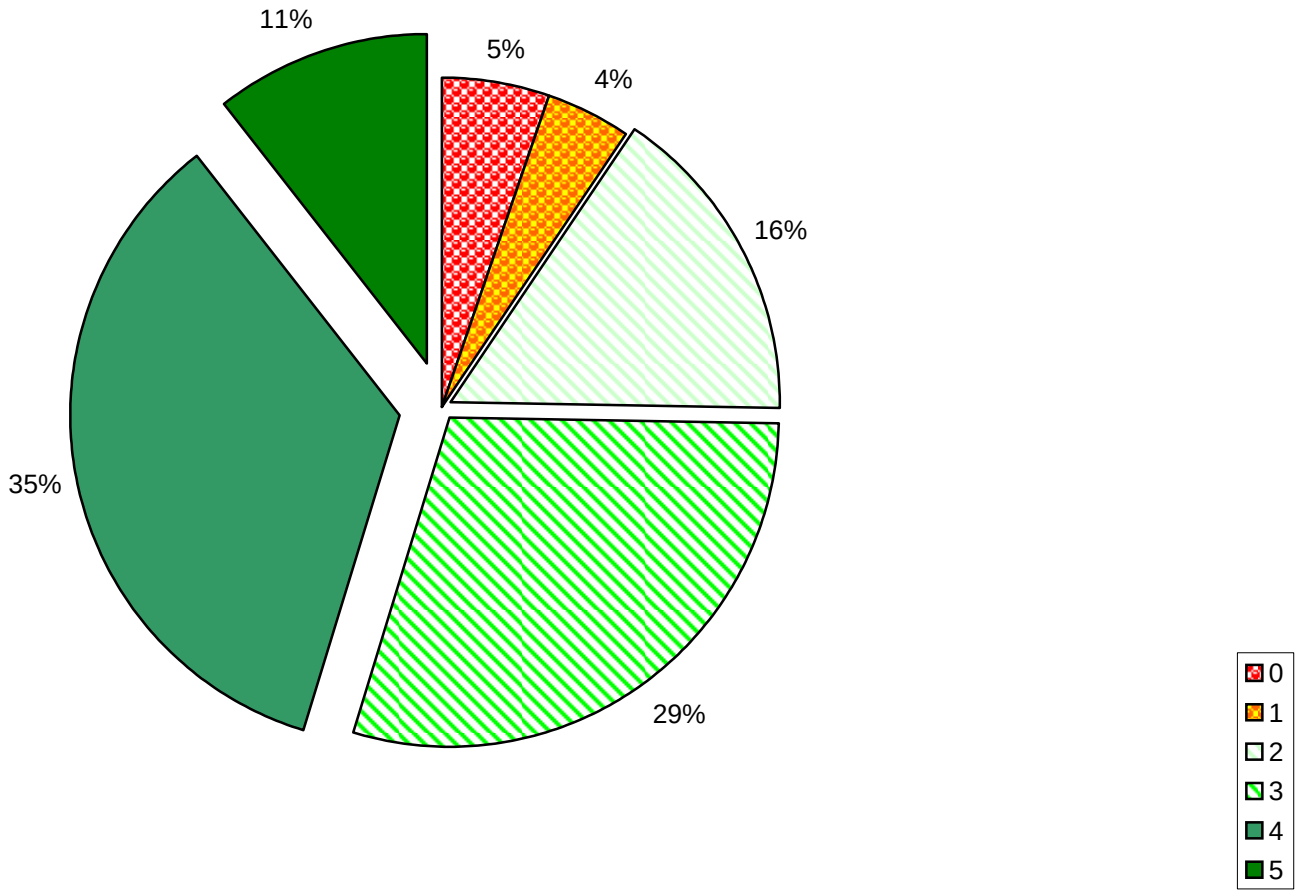


	North Sound	Timber-lands	Thurston	Pierce	North-east	King	Clark	Chelan-Douglas	Greater Colum-bia	North Central	Grays Harbor	Penin-sula	Spokane	South-west	Grand Total
5s	10	13	9	10	4	13	9	5	6	5	2	4	3	4	97
4s	33	20	18	16	11	9	12	9	15	9	13	14	5	3	187
3s	28	39	37	33	41	31	31	31	24	24	20	16	22	17	394
2s	15	21	20	22	16	27	35	34	15	32	38	43	39	35	392
1s	4	3	9	9	21	13	8	15	25	18	18	16	18	27	204
0s	5		3	5	3	3	1	1	11	8	5	3	9	10	67

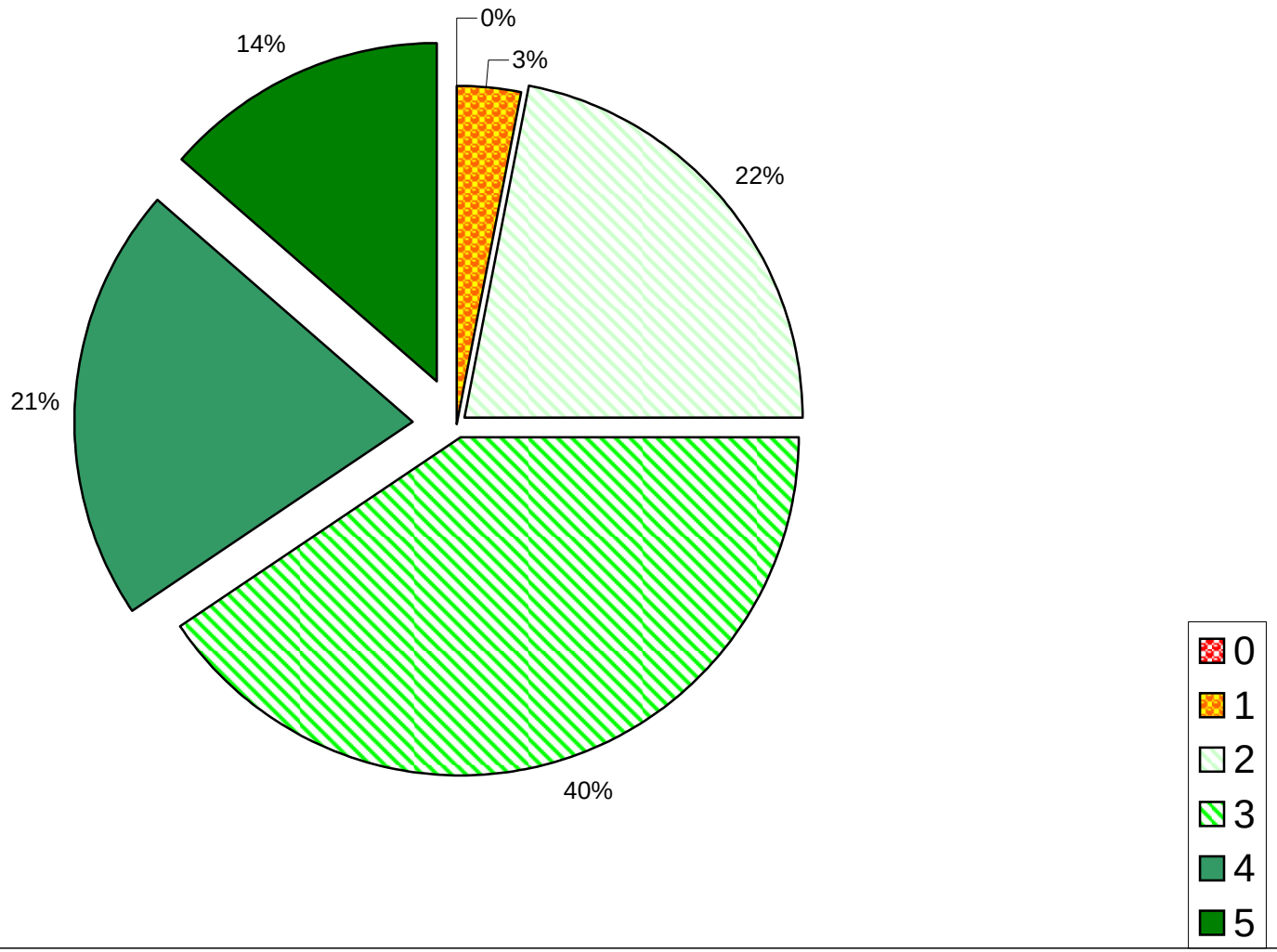
Visual 4
Overall Distribution of Scores



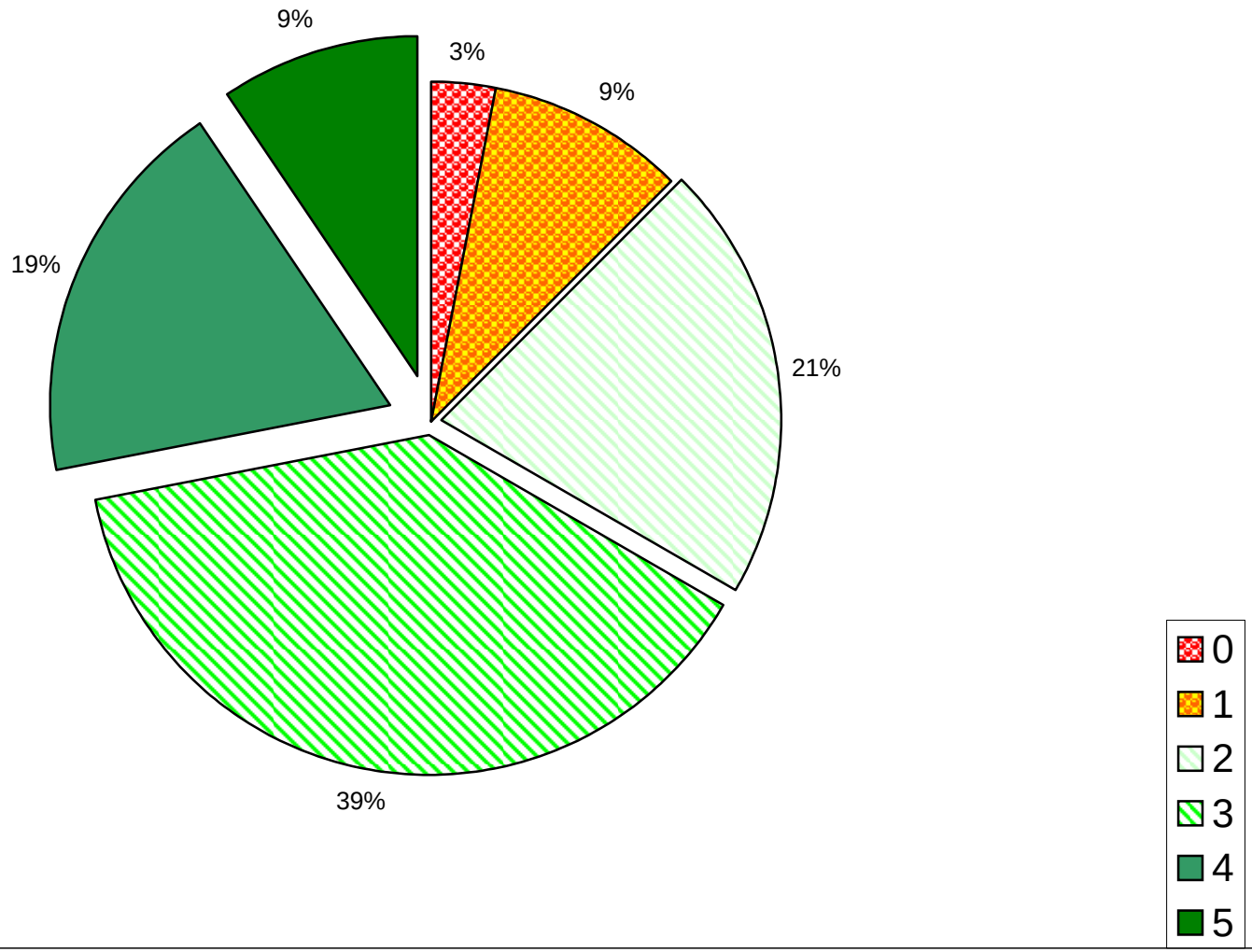
Visual 5
North Sound Distribution of Scores



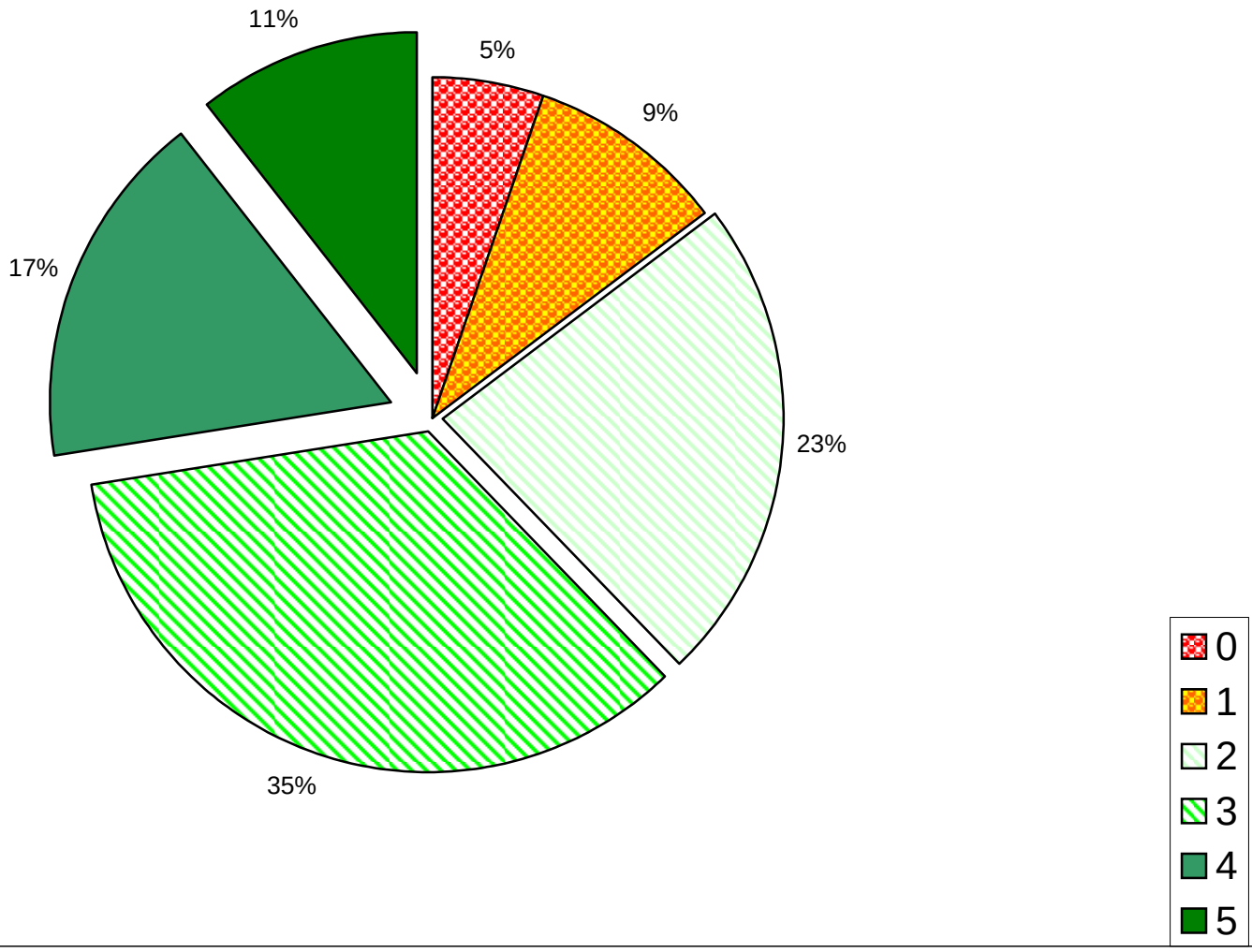
Visual 6
Timberlands Distribution of Scores



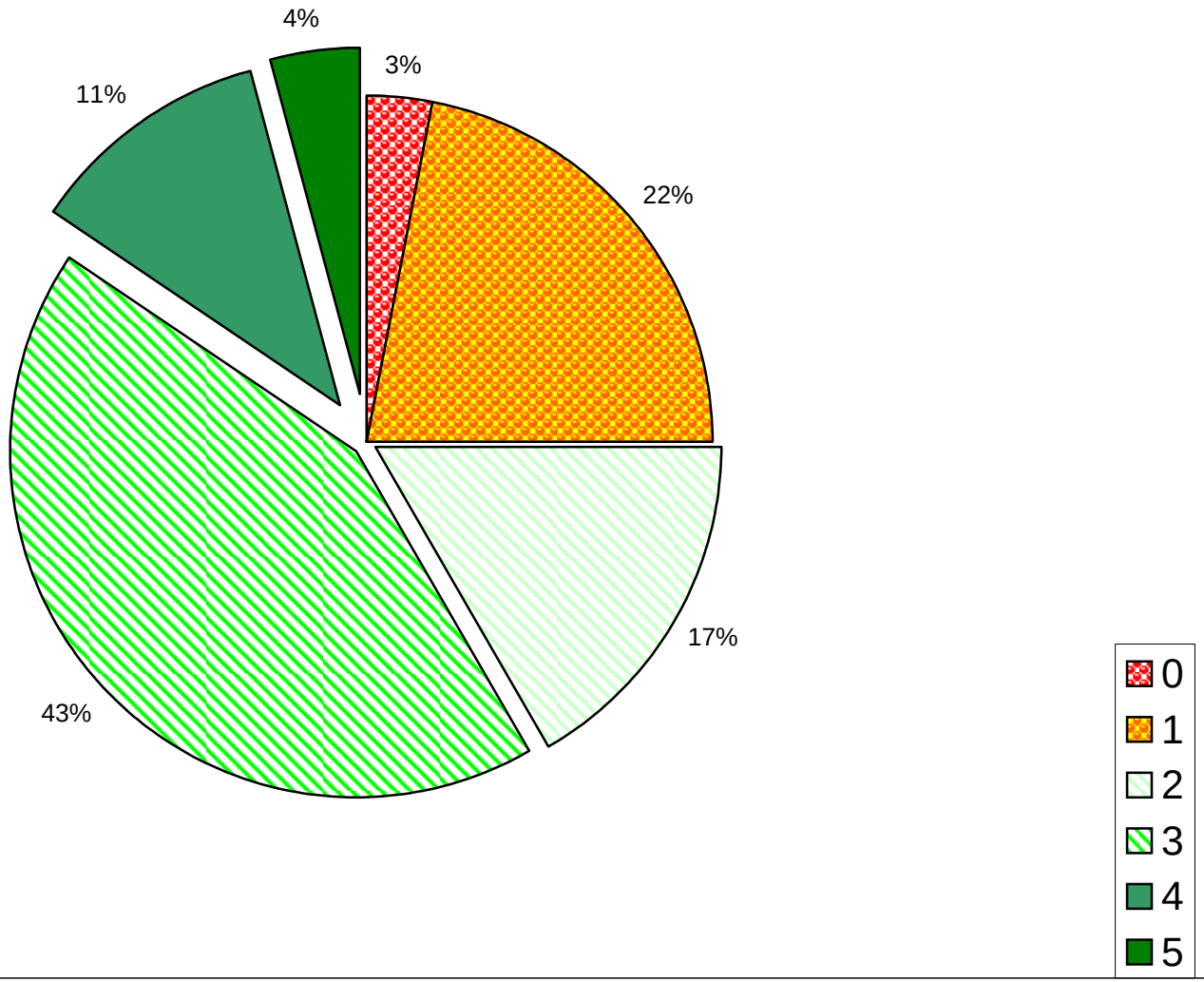
Visual 7
Thurston-Mason Distribution of Scores



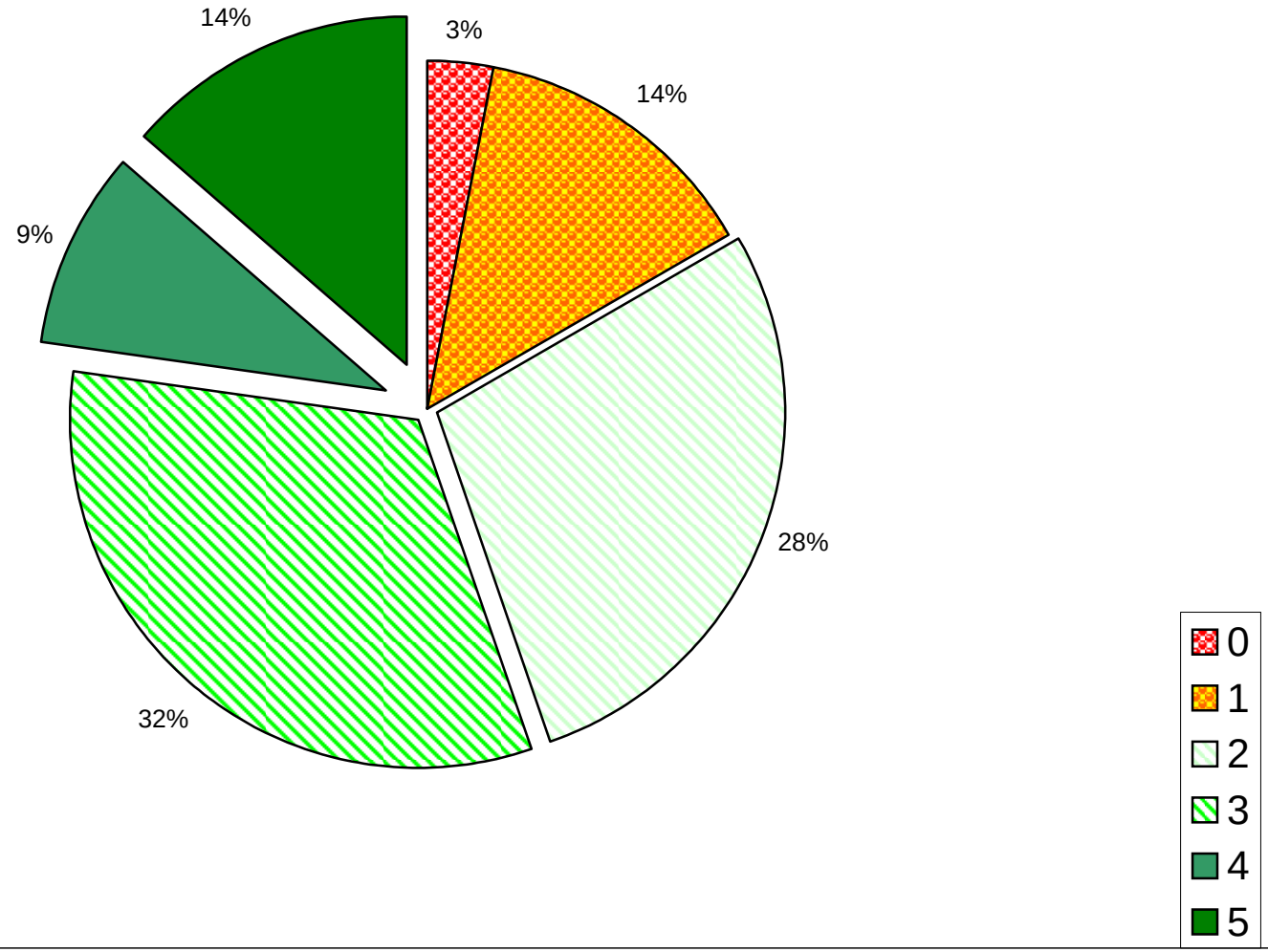
Visual 8
Pierce Distribution of Scores



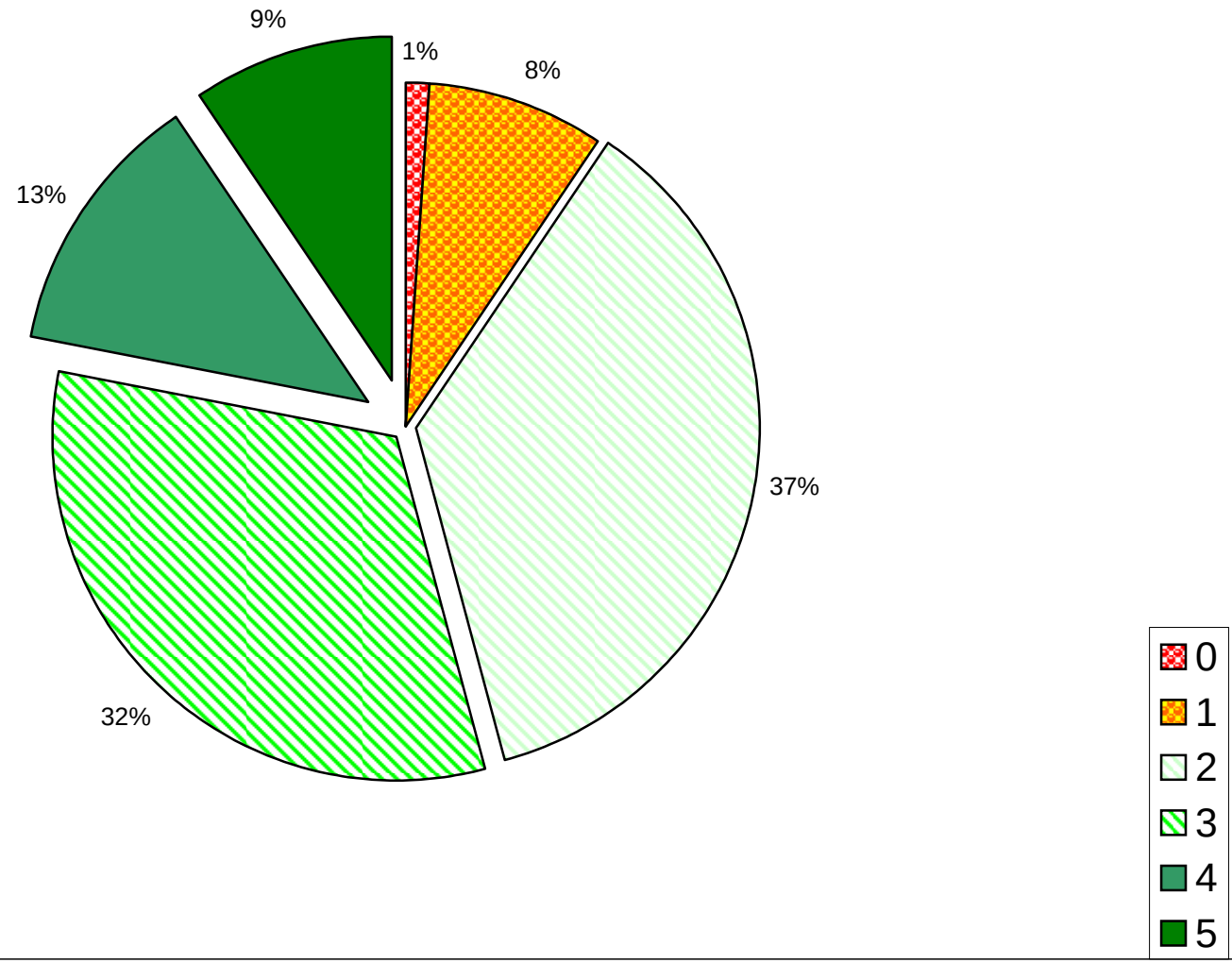
Visual 9
Northeast Distribution of Scores



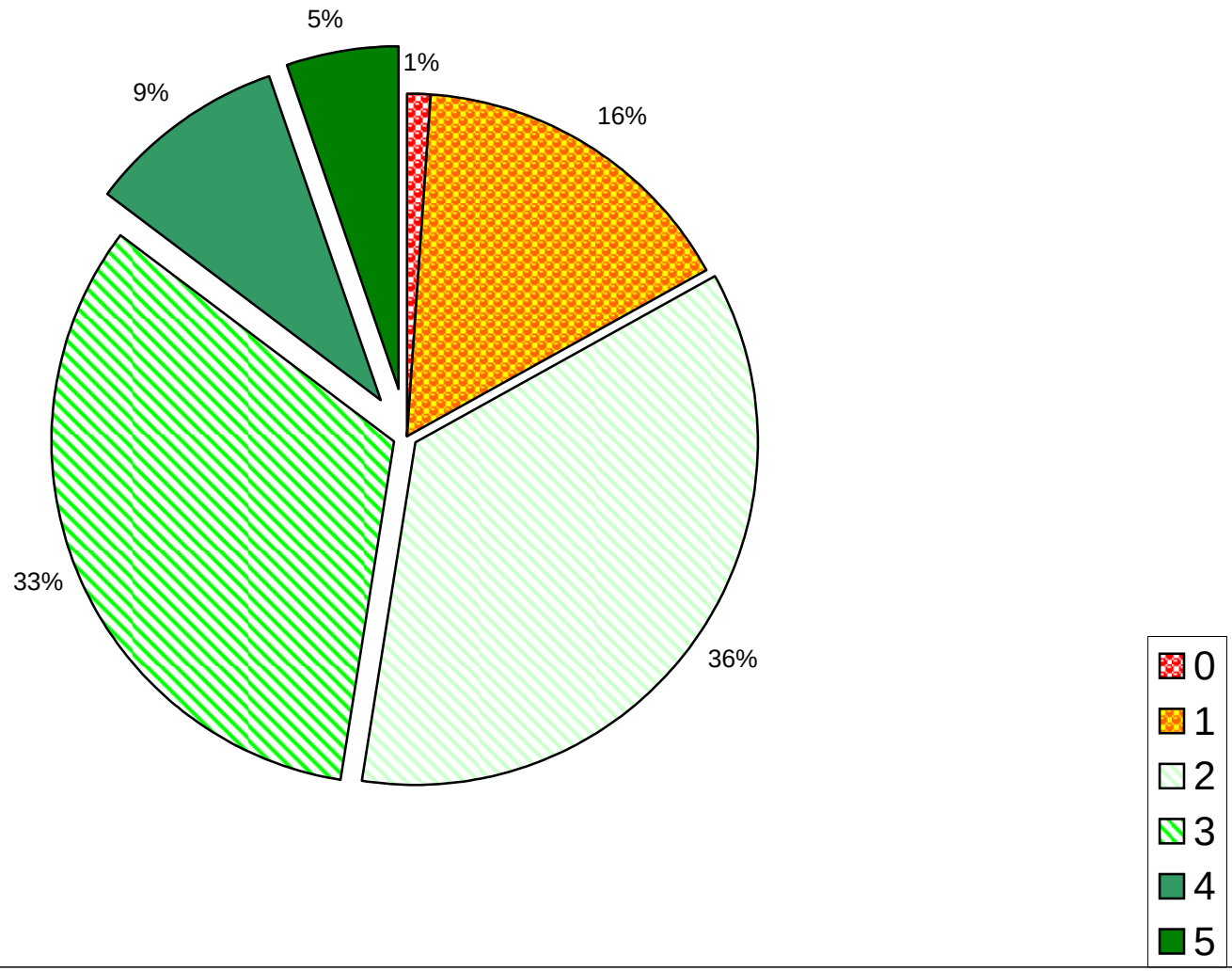
Visual 10
King County Distribution of Scores



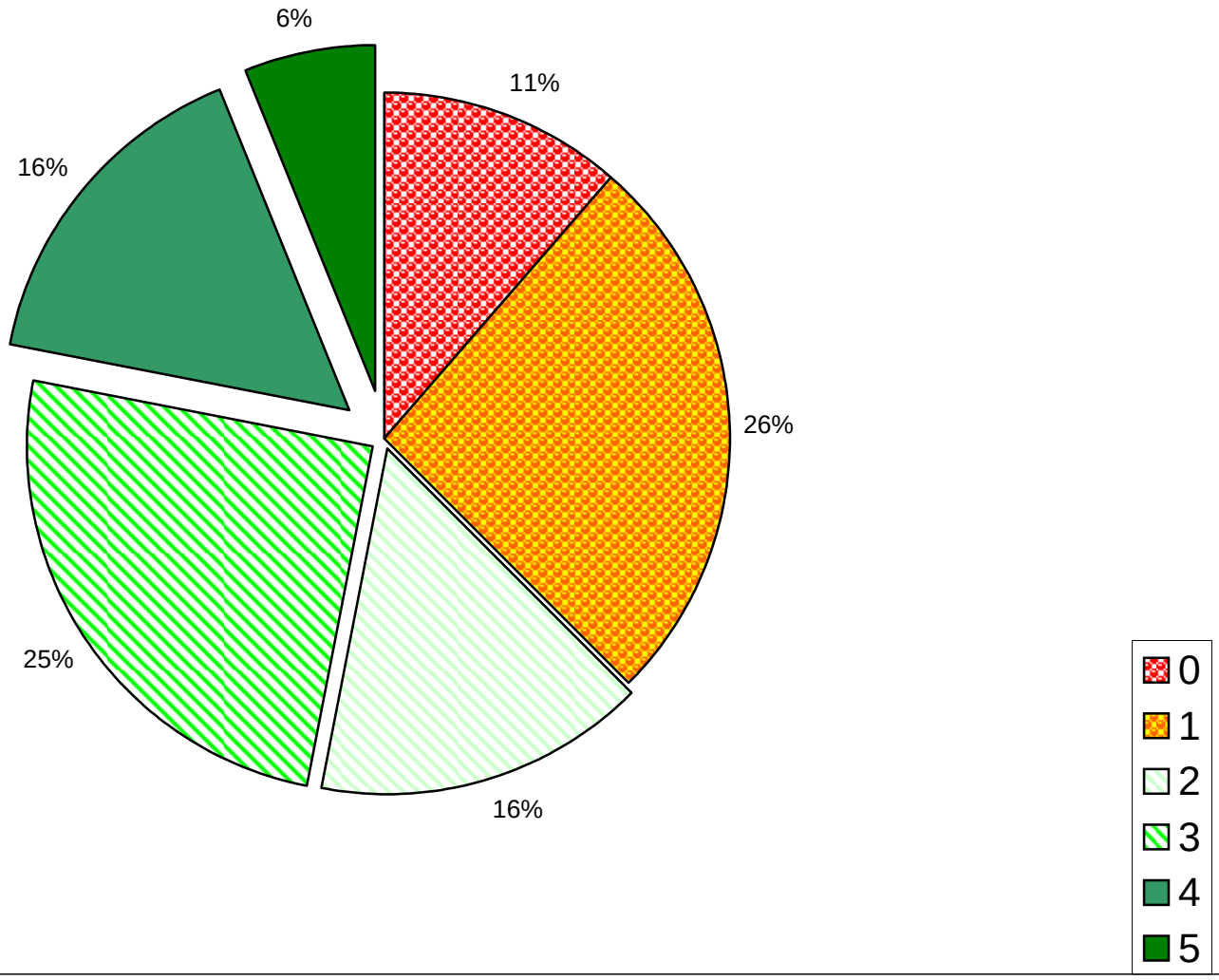
Visual 11
Clark County Distribution of Scores



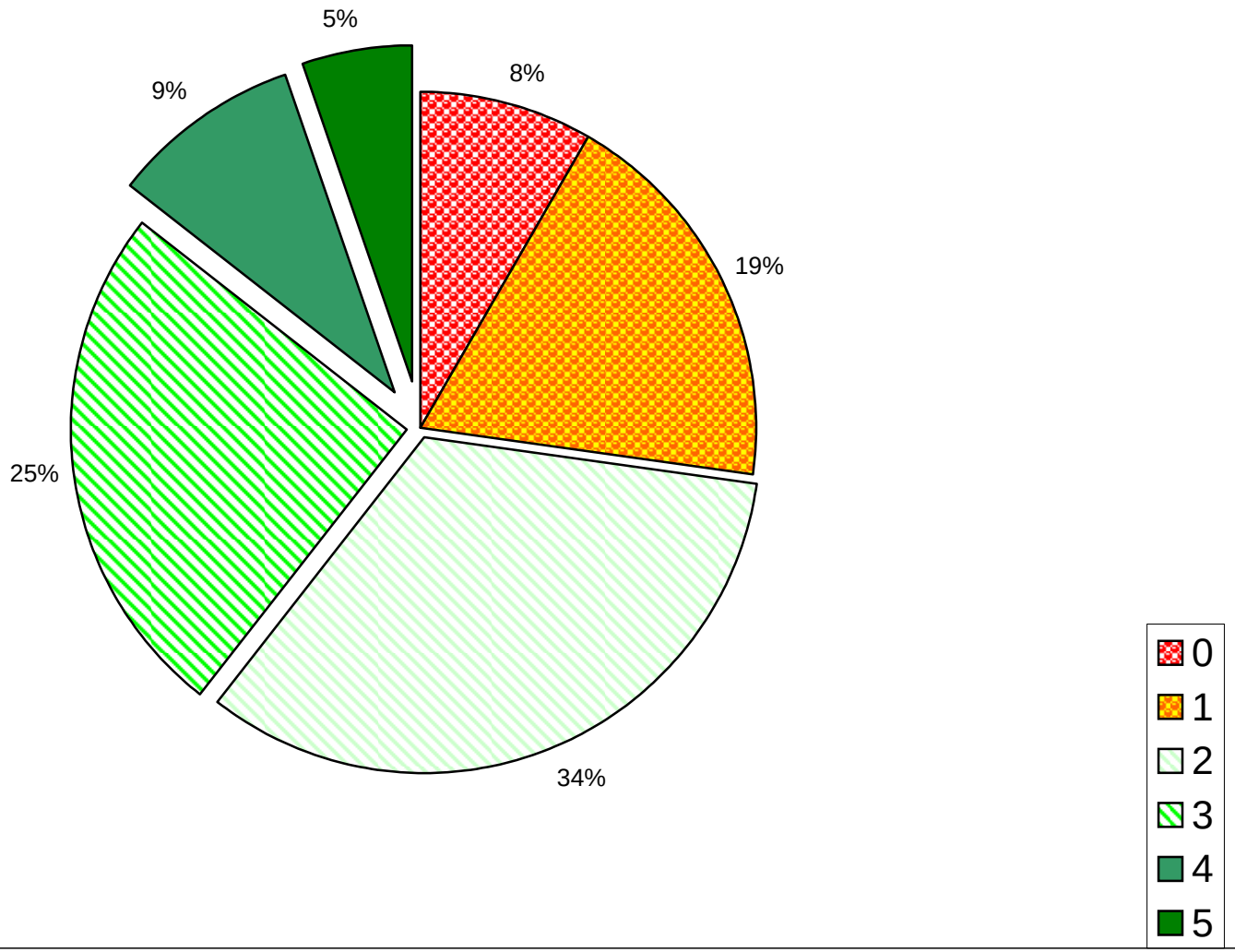
Visual 12
Chelan-Douglas Distribution of Scores



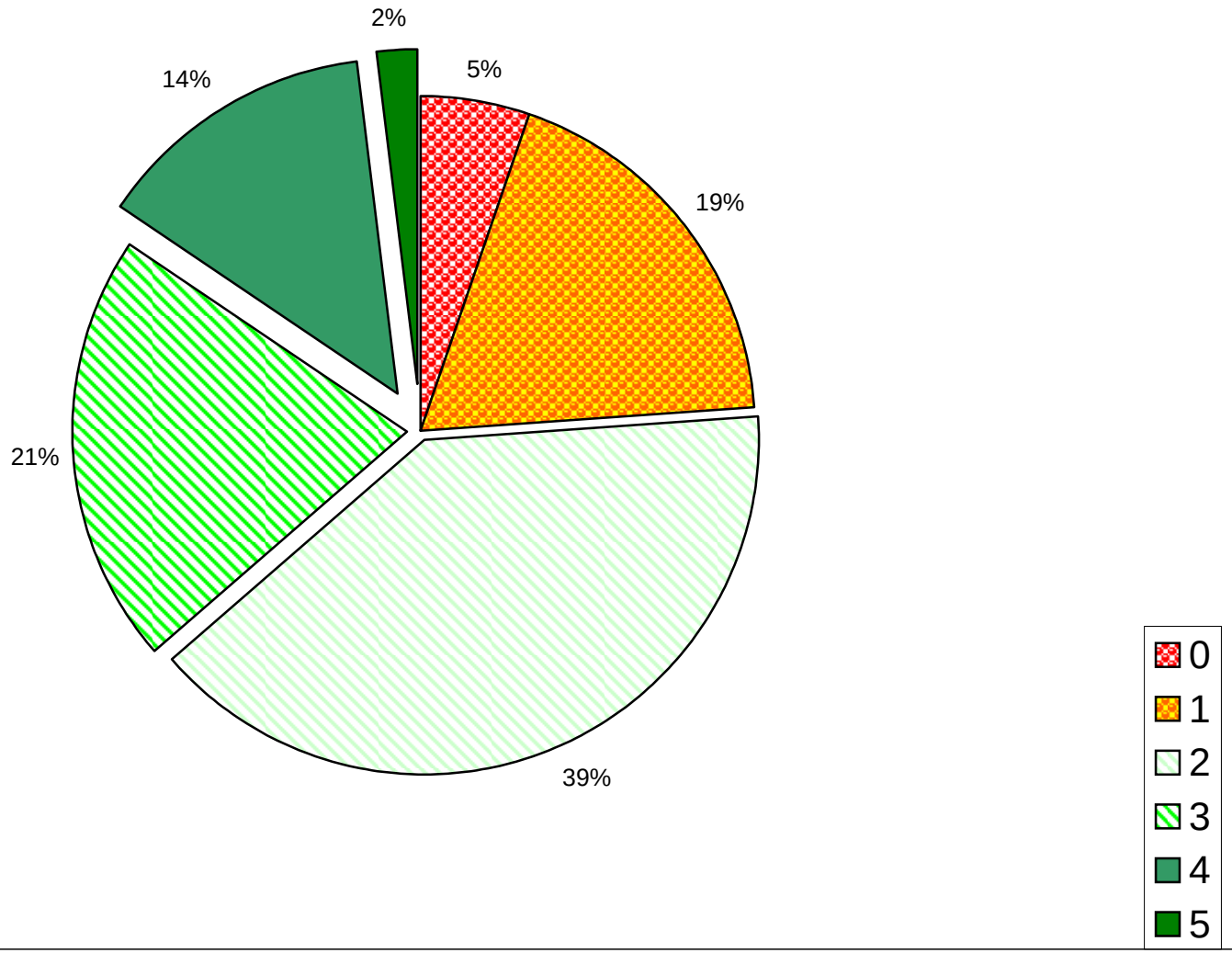
Visual 13
Greater Columbia Distribution of Scores



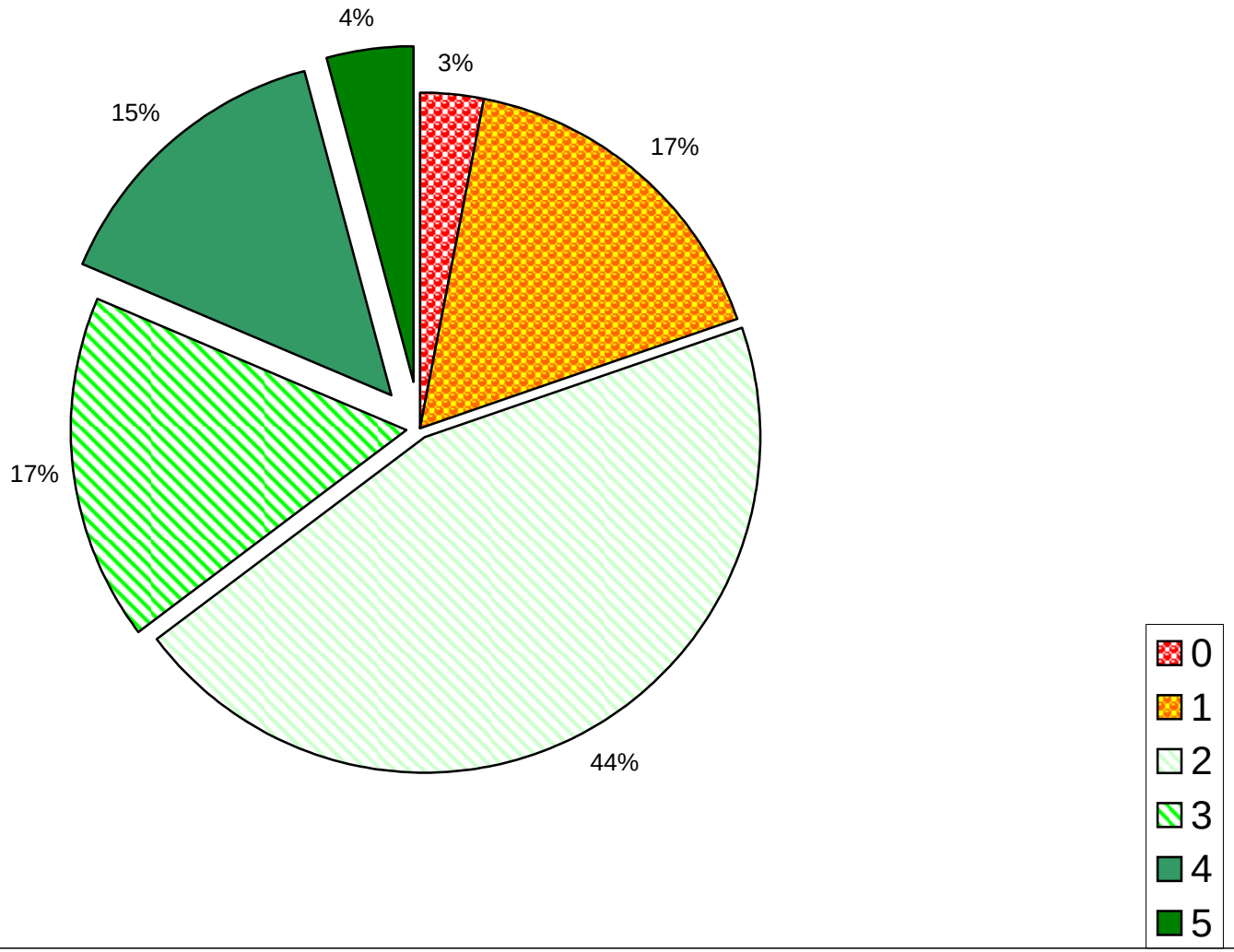
Visual 14
North Central Distribution of Scores



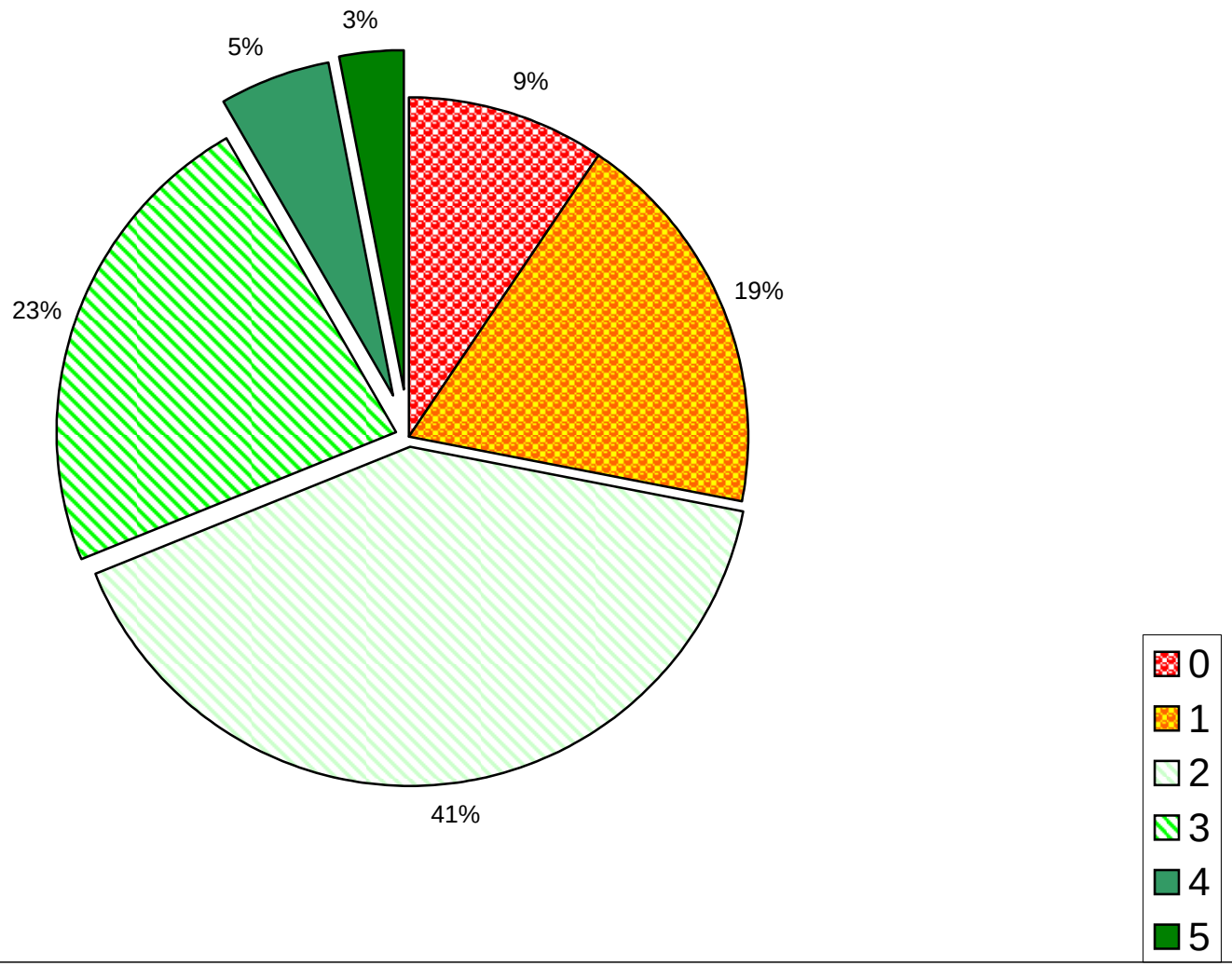
Visual 15
Grays Harbor Distribution of Scores



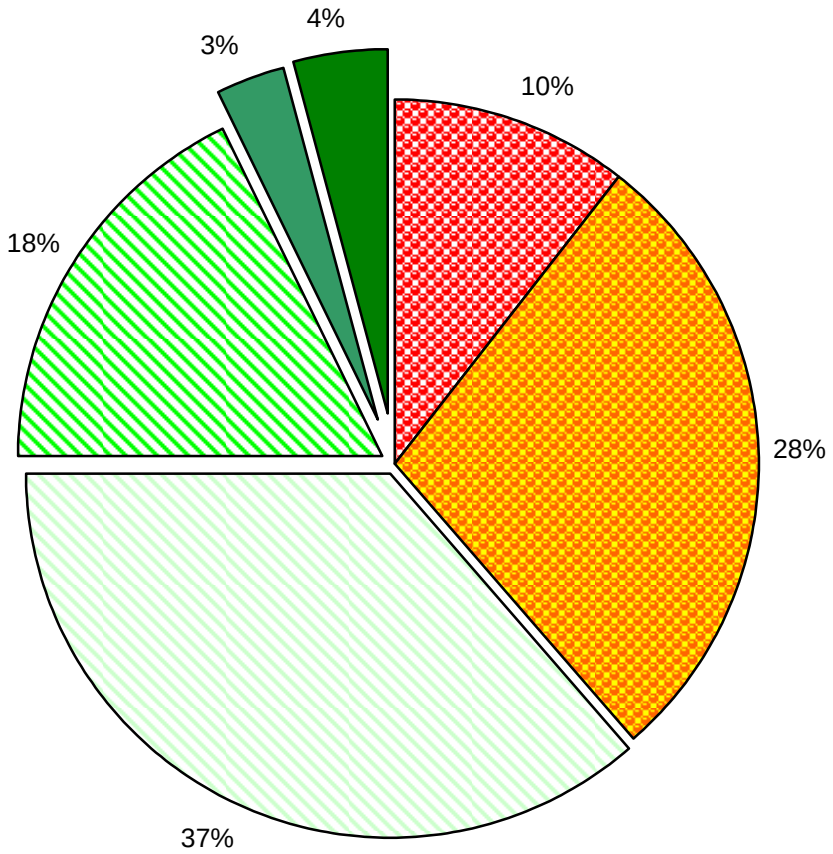
Visual 16
Peninsula Distribution of Scores



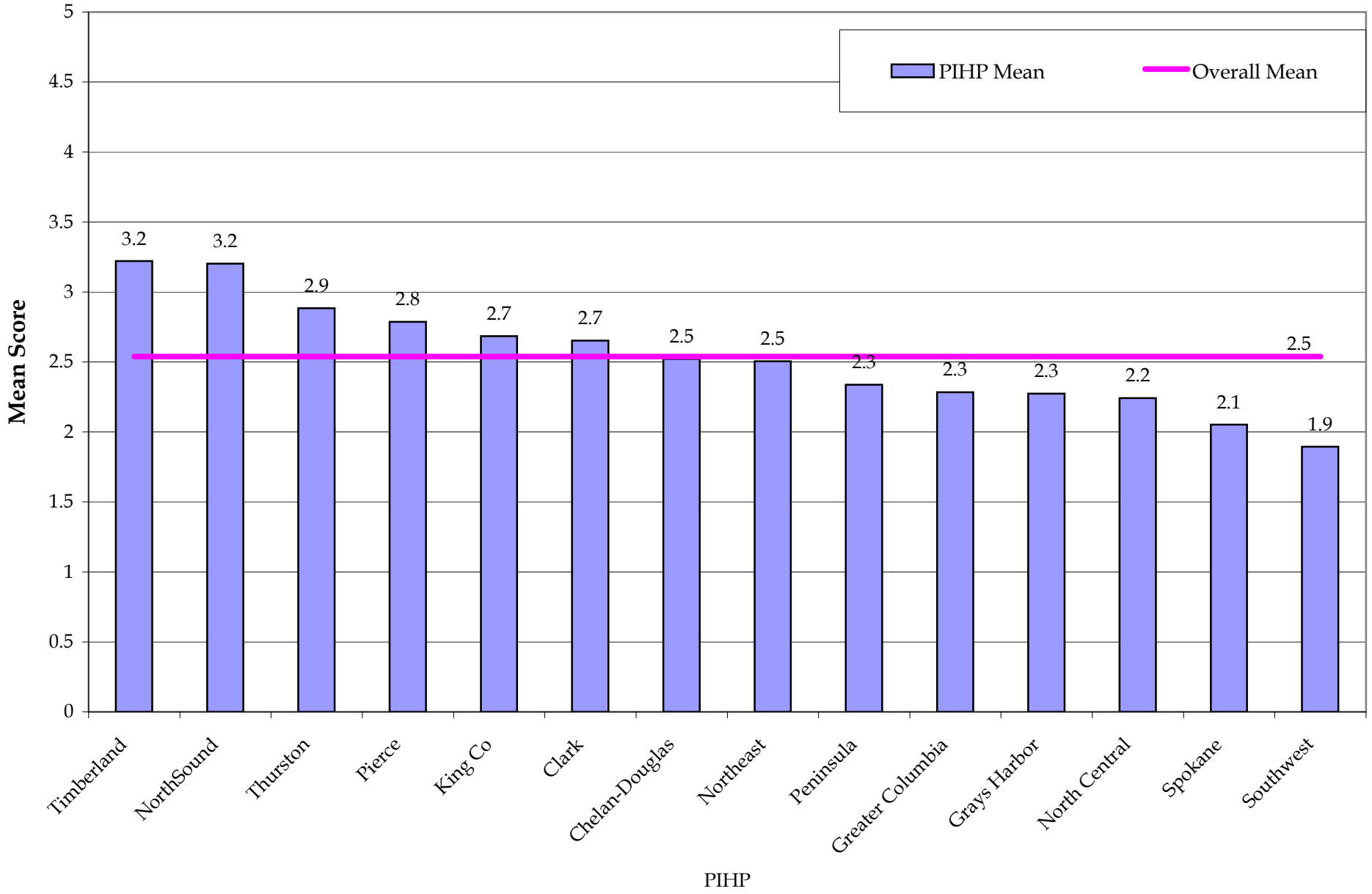
Visual 17
Spokane Distribution of Scores



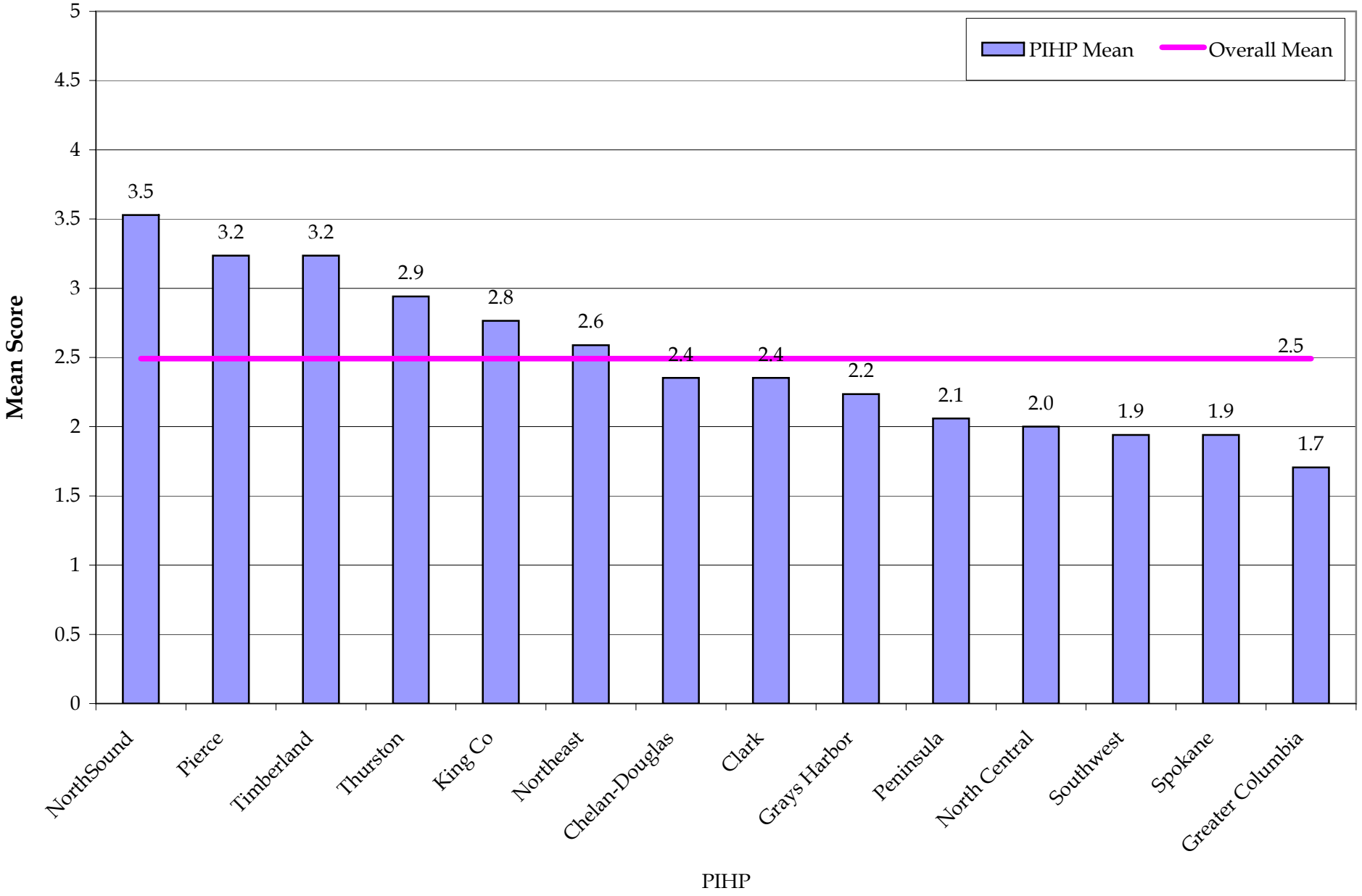
Visual 18
Southwest Distribution of Scores



Visual 19
Combined Subparts and Performance Measures

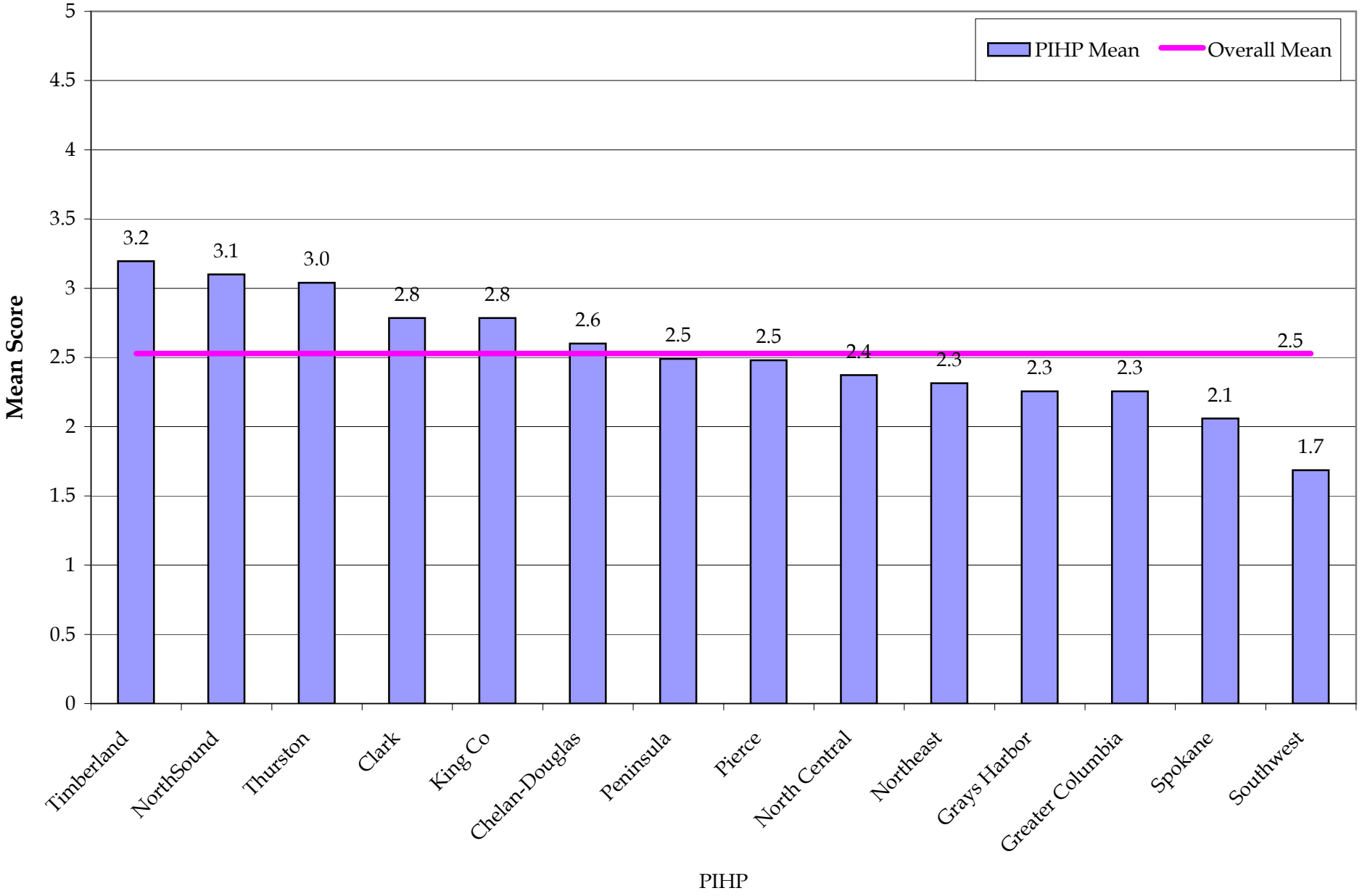


Visual 20
Subpart C - Enrollee Rights and Protection

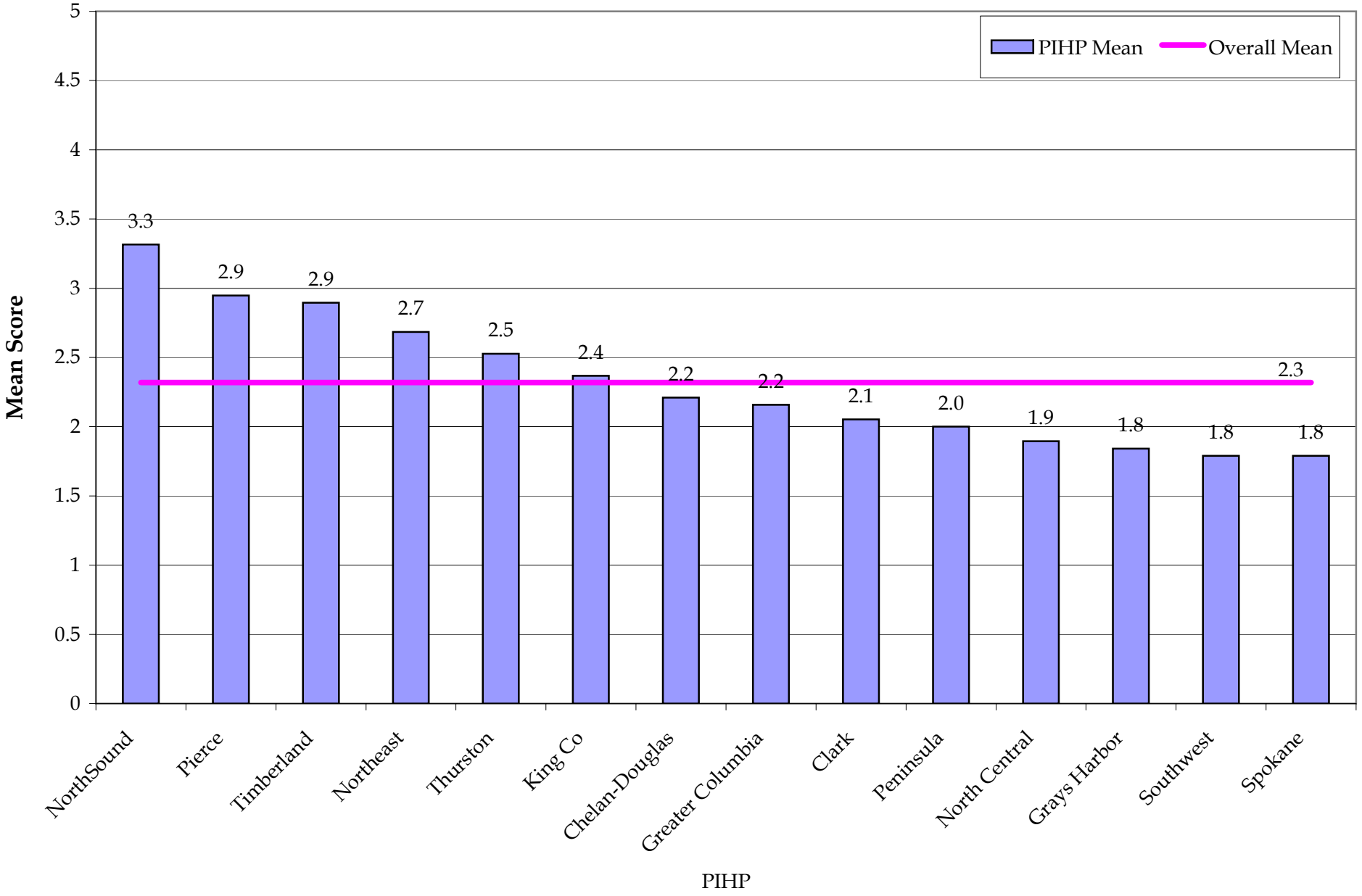


Visual 21

Subpart D - Quality Assessment and Performance Improvement

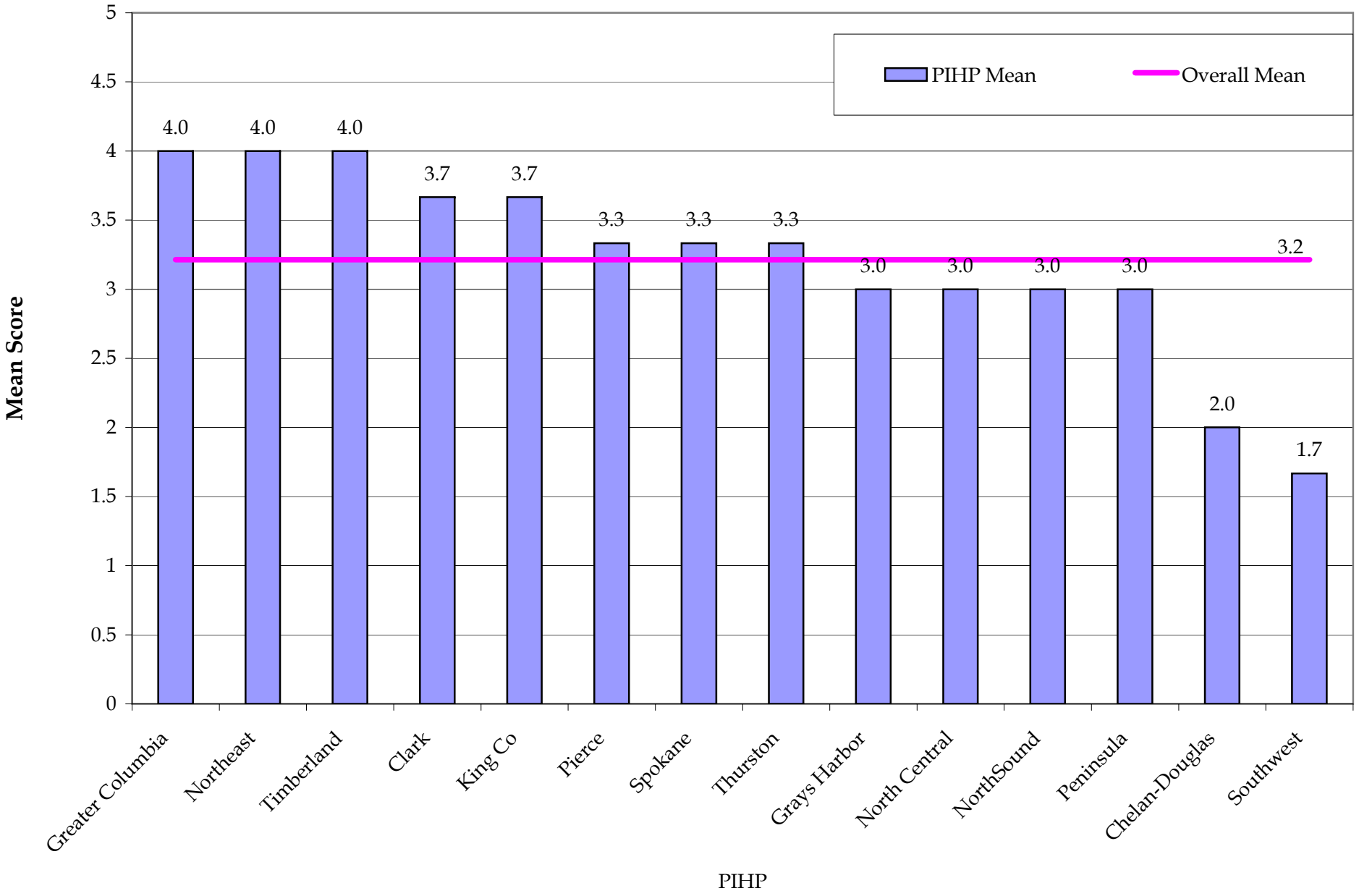


Visual 22
Subpart F - Grievance System

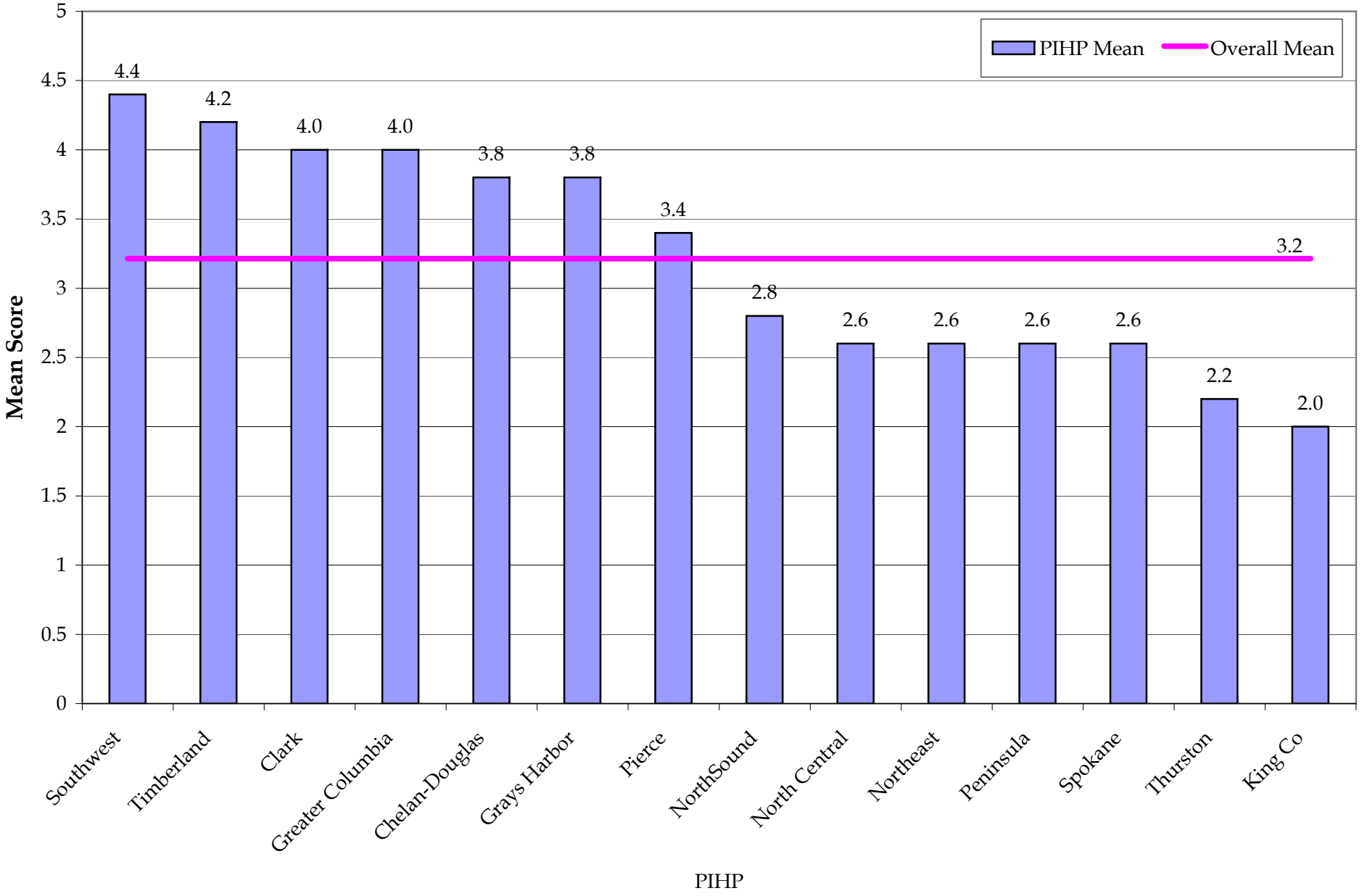


Visual 23

Subpart H - Certifications and Program Integrity



Visual 24
Performance Measures



Visual 25
Days to Submit Encounters

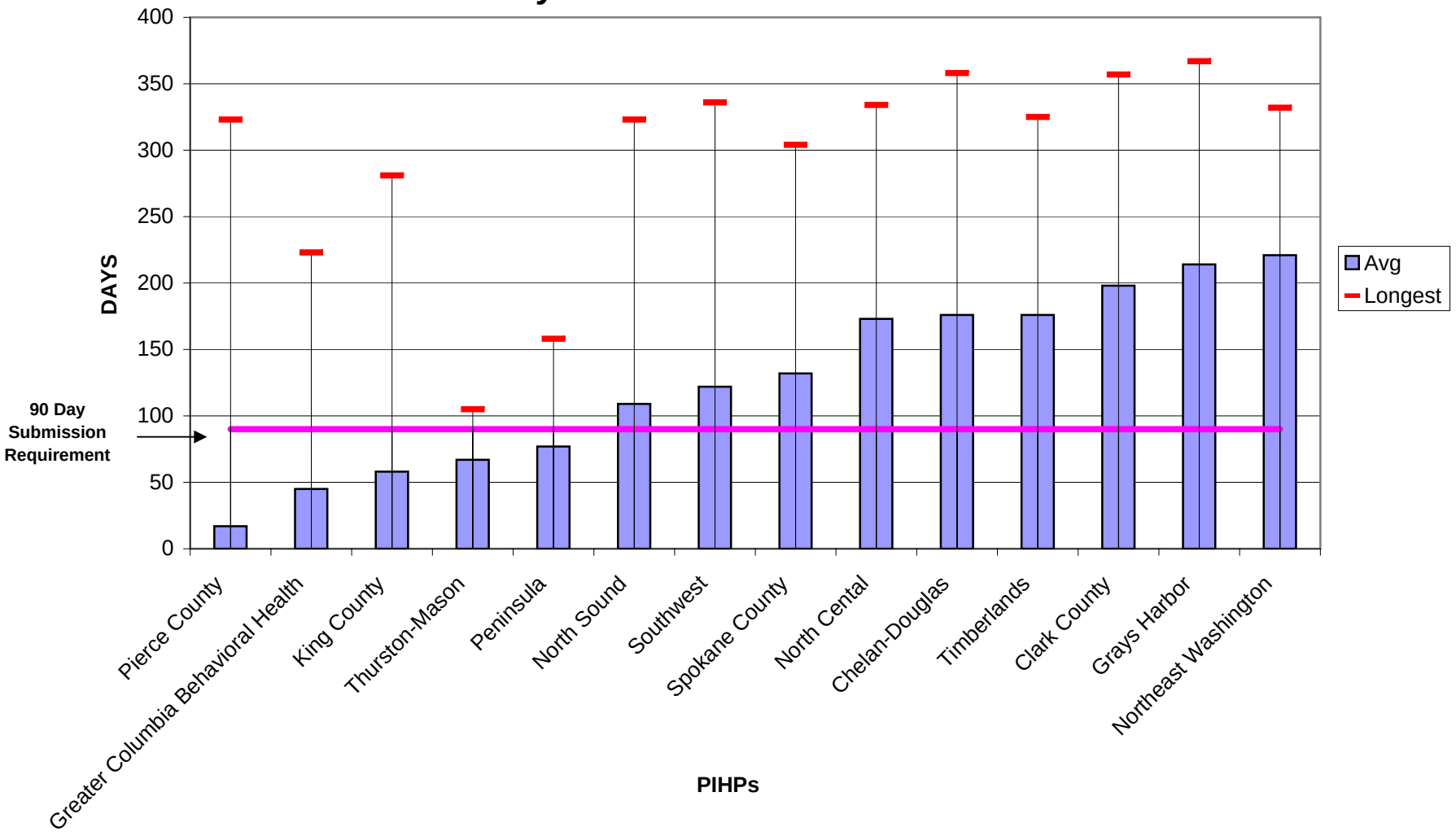


Table 1: Statistics for each Review Item

Item #	cfr	Average of Score	StdDevp of Score	Min of Score	Max of Score	Count of Score
1	438.10	2.21	1.21	1.00	4	14
3	438.100(b)	2.64	1.04	1.00	4	14
4	438.100(b)	1.71	0.80	1.00	3	14
5	438.100(b)	2.21	1.26	0.00	5	14
6	438.100 (c)	2.57	1.12	1.00	5	14
7	438.100(d)	2.50	1.24	1.00	4	14
8	438.100(d)	3.57	0.90	2.00	5	14
9	438.100(d)	2.50	0.82	1.00	4	14
10	438.100(d)	2.71	1.03	1.00	5	14
11	438.100(d)	2.14	1.19	1.00	5	14
12	438.102	3.21	0.94	2.00	5	14
13	438.106	1.93	0.88	0.00	3	14
14	438.10(g)	2.43	1.24	1.00	4	14
15	438.10(g)	2.57	1.05	0.00	4	14
16	438.10(g)	2.93	0.80	2.00	4	14
17	438.10(g)	1.79	1.26	0.00	4	14
18	438.206(b)(1)	3.07	1.03	1.00	5	14
19	438.206(b)(1)	2.79	1.08	0.00	4	14
20	438.206(b)(1)	2.86	1.06	1.00	5	14
21	438.206(b)(2)	2.21	0.77	1.00	4	14
22	438.206(b)(4)	2.00	1.00	0.00	4	14
23	438.206(b)(5)	1.86	0.74	0.00	3	14
24	438.206(b)(5)	1.71	1.10	0.00	4	14
25	438.206©(1)	3.43	0.90	2.00	5	14
26	438.206©(1)	3.29	0.80	2.00	5	14
27	438.206©(1)	2.64	1.29	1.00	5	14
28	438.206©(2)	3.71	1.16	1.00	5	14
29	438.206©(2)	1.93	0.88	1.00	4	14
30	438.206©(2)	2.93	0.80	1.00	4	14
31	438.206©(2)	3.79	0.77	3.00	5	14
32	438.206©(2)	2.21	0.77	1.00	3	14
33	438.206©(2)	2.86	0.99	1.00	4	14
34	438.207	2.71	1.03	1.00	5	14
35	439.207	3.07	1.22	0.00	5	14
36	438.208©	3.00	1.31	1.00	5	14
37	438.208©	3.36	0.72	2.00	4	14
38	438.208©	1.29	1.28	0.00	4	14
39	438.210(b)	2.43	0.82	1.00	4	14
40	438.210(b)	2.21	1.15	0.00	4	14
41	438.210(b)	2.07	1.10	0.00	4	14
42	438.210©	1.50	1.05	1.00	5	14
43	438.10(d)	1.86	1.12	0.00	5	14
44	438.10(d)	1.79	0.94	0.00	3	14
45	438.10(d)	1.36	0.97	0.00	3	14
46	438.210(e)	1.42	1.11	0.00	3	12
47	438.214©	2.29	1.16	0.00	4	14
48	438.12	3.29	0.88	2.00	5	14
49	438.224	3.93	1.28	1.00	5	14
50	438.224	3.50	1.12	1.00	5	14
51	438.224	1.93	1.71	0.00	5	14
52	438.230(b)	1.79	1.21	0.00	5	14
53	438.230(b)	1.92	1.49	0.00	5	13
54	438.230(b)	1.93	1.22	1.00	5	14
55	438.230(b)	2.14	1.46	0.00	5	14
56	438.236	2.00	1.13	1.00	5	14
57	439.236	1.71	1.16	0.00	4	14
58	440.236	0.93	0.80	0.00	2	14
59	438.24	4.00	0.93	2.00	5	14
60	438.24	2.50	0.73	2.00	4	14
61	438.24	2.50	1.12	1.00	5	14
62	438.24	2.93	1.22	0.00	5	14
63	438.24			0.00	0	0
64	438.24	2.57	0.98	1.00	5	14
65	438.24			0.00	0	0
66	438.24	3.79	0.77	2.00	5	14
67	438.24	3.36	0.81	2.00	4	14
68	438.242	5.00	0.00	5.00	5	14
69	438.242	2.07	1.28	0.00	4	14
70	438.242	2.00	1.65	0.00	4	14
71	438.402	2.50	0.98	1.00	5	14
72	438.402	2.14	1.06	0.00	4	14

Item #	cfr	Average of Score	StdDevp of Score	Min of Score	Max of Score	Count of Score
73	438.404	1.43	0.62	1.00	3	14
74	438.406	2.57	0.90	1.00	4	14
75	439.406	2.36	0.61	1.00	3	14
76	440.406	2.57	0.49	2.00	3	14
77	441.406	2.43	0.90	1.00	5	14
78	442.406	2.29	0.59	1.00	3	14
79	443.406	2.07	0.96	0.00	3	14
80	438.408	2.36	0.48	2.00	3	14
81	438.408	2.50	0.63	2.00	4	14
82	438.408	2.21	0.77	1.00	4	14
83	438.41	2.36	0.48	2.00	3	14
84	439.41	2.36	0.61	1.00	3	14
85	438.414	2.71	0.70	1.00	4	14
86	438.416	2.50	0.82	1.00	4	14
87	439.416	2.50	0.82	1.00	4	14
88	438.42	2.07	0.70	1.00	3	14
89	438.424	2.29	0.80	0.00	3	14
90	438.606	3.64	1.95	0.00	5	14
91	438.608	3.21	0.77	2.00	4	14
92	438.61	2.79	0.94	1.00	5	14
PM1	Performance Measures	3.57	0.49	3.00	4	14
PM2	Performance Measures	1.79	1.90	0.00	5	14
PM3	Performance Measures	3.00	0.00	3.00	3	14
PM4	Performance Measures	2.50	0.91	1.00	4	14
PM5	Performance Measures	1.86	0.99	1.00	3	14
PM6	Performance Measures	5.00	0.00	5.00	5	14
Grand Total		**2.54**	**1.25**	**0.00**	**5**	**1327**

WASHINGTON STATE
PIHP EXTERNAL QUALITY REVIEW
SUBPART REPORT

PROTOCOL SUBPART REVIEW SUMMARY

Each of the fourteen (14) Protocol Subpart Onsite Reviews conducted by the External Quality Review Organization (EQRO) started with a review of the documents prepared and submitted by the Prepaid Inpatient Health Plans (PIHP). This provided an opportunity to make initial determinations of whether or not the PIHPs were in compliance with each of the regulations. Additional information and documents were requested from the PIHPs as part of this process. The Subparts addressed in the reviews included:

- Subpart C-Enrollee Rights and Protections
- Subpart D-Quality Assessment and Performance Improvement
- Subpart F-Grievance System
- Subpart H-Certifications and Program Integrity

The document reviews were followed by onsite interviews with members of the PIHPs' Provider Networks where enrollees of the PIHPs actually receive care. Additional information and data were collected on functions delegated to the Network Providers by the PIHPs and the degree to which the PIHPs' policies, procedures and mechanisms were integrated throughout each regional system of care. Interviews were then conducted with key staff of each PIHP responsible for implementing their PIHP's managed care functions. The reviewers recorded information in the Documentation and Reporting Tools that were utilized by the reviewers as aids in the process of making determinations about compliance with each of the regulatory provisions. Every onsite review ended with a summation conference in which the reviewers identified some of the PIHP's key strengths and opportunities for improvement.

Once each of the Protocol Subpart Onsite Reviews were completed, the PIHPs were given ten (10) working days to submit any additional documentation they were unable to produce and/or additional documentation requested by the reviewers at the time of their onsite review. Once all of the documentation submitted by a PIHP was received and reviewed, a Subpart report was drafted by the onsite reviewers. The draft report included a written assessment of the evidence provided and the interviews conducted during the onsite review, as well as scores depicting the degree of the PIHP's compliance with each of the regulations. The EQRO utilized the documentation tools and scoring guidelines provided by the Washington State Mental Health Division (MHD) to assist in the determination of each PIHP's degree of compliance with each regulation.

The scores ranged from zero (0) to five (5) with zero (0) = No Compliance, one (1) = Insufficient Compliance, two (2) = Partial Compliance, three (3) = Moderate Compliance, four (4) = Substantial Compliance and five (5) = Maximum Compliance.

The PIHPs were then given a chance to review their report and submit any rebuttal or additional evidence they felt was undiscovered during the onsite review. Rebuttal and or additional documentation received from the PIHPs were reviewed by the EQRO and compliance scores were adjusted according to the relevance of the additional documentation. The EQRO Executive Director then conducted a final debriefing with the PIHP Administrator to explain any changes that would be made to the original draft.

The following State-wide Compliance Determination Report collectively summarizes Washington State's fourteen (14) PIHPs' compliance to the Code of Federal Regulations (CFR) requirements identified in Subparts C, D, F, and H Within each subpart section there is a list of the PIHPs' strengths and opportunities for improvement pertaining to that specific subpart. The report begins with a detailed review of the State-wide systemic opportunities for improvement that the EQRO determined as most vital.

FUNDAMENTAL SYSTEMIC OPPORTUNITIES FOR IMPROVEMENT

438.10(c) Information Requirements/438.206(c)(2) Culturally Competent Service Delivery

Translation of client materials clearly emerged as an opportunity for improvement for all the PIHPs throughout the State. It is important to acknowledge that all fourteen (14) PIHPs had available the most recent Department of Social and Health Services (DSHS) Public Mental Health System Benefits Booklet in all seven (7) DSHS languages (Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese, and English). However, beyond the Benefits Booklet the available translated client materials were few and inconsistent from one PIHP to another. The PIHPs reported confusion and lack of understanding as to what client materials are specifically required to be translated. Some PIHPs understood that client rights were all that needed to be translated. Others believed that client materials included not only client rights, but also grievance materials, HIPAA protections of confidentiality, Advance Directives and all client intake and orientation materials. The PIHPs also expressed confusion about whether they were to have translated client materials for the "prevalent" languages spoken in their regions or for all seven (7) languages designated by DSHS. Also absent were materials for individuals who are blind, deaf or hard of hearing. The EQRO recommends the State establish a standard definition for what constitutes "client materials" and clarify the translation requirements with regard to "prevalent" regional languages vs. the seven (7) languages designated by DSHS.

438.210(c) and 438.404 Notice of Actions

In the past twelve (12) months all fourteen (14) PIHPs made efforts to revise or create new grievance system policies and procedures that contained the requirements of Notice of Actions as outlined in 42 CFR 438.210(c) and 42 CFR 438.404. The PIHPs policies and procedures stipulate the PIHP will issue a Notice of Action in the event of a reduction, termination, or suspension of enrollees previously authorized medically necessary services, as well as for denials based on lack of medical necessity. With the exception of one (1) PIHP, when staff at the PIHPs and Network Providers were interviewed, it was consistently reported by all that denial determinations have been occurring based on lack of medical necessity and no Notice of Actions have been sent out to enrollees by the PIHPs or the Providers in the past twelve (12) months. The reviewers believe that this is mostly due to either confusion as to what is truly a denial and/or because the issuance of denials have been unofficially delegated to the provider. Many of the PIHPs' grievance system policies and procedures state, "The decision by a Community Mental Health Agency (CMHA) not to provide a covered service is not a denial and cannot be appealed." Therefore, when Network Providers are conducting medical necessity determinations and issuing denials without sending a Notice of Action to the enrollee they are limiting and restricting enrollees from freely exercising their rights to appeal a "denial"

based on lack of medical necessity. The EQRO recommends that the State clarify with the PIHPs an operational definition of what a denial is for inpatient and outpatient services, give direction as to how to standardize the Notice of Action process State-wide and mechanisms to monitor denials and track trends. Without consistent State-wide use and tracking of the Notice of Action letters there can be no assurance that enrollees' rights are not being violated.

438.210(e) Compensation for Utilization Management Activities

The review of all fourteen (14) PIHPs brought to light the variety of ways the PIHPs contract and compensate their Network Providers as well as how their utilization management (UM) activities differ. In particular, it was discovered by the reviewers that the initial authorization of services may be unofficially contracted to Network Providers. At some PIHPs authorizations happen via an automatic electronic process, while other PIHPs manually conduct authorizations, some have no formal authorization process and yet others may have Network Providers perform initial authorizations, with the exception of denials that are reviewed by the PIHP for final determination. It also became evident that inpatient authorization processes were more similar from PIHP to PIHP and appeared to be more formalized. However, it was of concern to the reviewers that utilization management practices across the State lacked clarity, consistency and collective understanding of the benefits to well designed utilization management plans. Of greatest concern was a lack of mechanisms in place, predominantly with regard to outpatient UM that protect against financial incentives to authorize in such a way to minimize or maximize financial risk. Currently, the majority of the PIHPs' UM designs are insufficient to detect fraud and abuse (intentional and/or unintentional), particularly with regard to under and over utilization when Provider holds risk. When Network Providers are unofficially delegated responsibility for authorization of services, the potential for (intended or unintended) incentives are especially vulnerable. Currently the PIHPs do not have in place adequate monitoring and oversight to detect under and over utilization. The EQRO recommends that the State provide direction in defining best practice standards for managed care utilization management that is consistently implemented throughout all the PIHPs. Effective utilization management will enable the PIHPs and their Network Providers to effectively manage high-risk consumers, cut down on inappropriate use of expensive services, to develop programming that addresses the needs of their member populations, arbitrate denials of services and demonstrate to customers enhanced efficiency and quality of care.

438.230 SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

It appears that it has been common practice for the PIHPs in Washington State to delegate management information services, enrollee information, intake assessment, determination of medical necessity, utilization management and the like to subcontracted Network Providers. The concern here is that the PIHPs have not conducted formal and adequate evaluations of the Network Providers' ability to perform these delegated activities prior to their delegation. In addition

the PIHPs are not consistently monitoring the subcontractor's performance related to the delegated functions on an annual basis according to a periodic schedule established by the State. It is also of concern that the written agreements do not adequately specify the activities and responsibilities associated with these delegated functions. As a result, the roles and responsibilities of the PIHPs and their Network Providers are sometimes indistinguishable, at other times come into conflict and can even create gaps in the system of care. An example of the latter is PIHPs unofficially delegating the issuance of denials to their Network Providers. However, by definition Notice of Actions must be issued by the PIHPs. No Notices of Actions were being issued and therefore enrollees were not allowed the opportunity to appeal their denial. The EQRO recommends the State establish an annual review schedule in conjunction with the PIHPs. Additionally, establish qualifications and performance criteria for specific delegated functions and ensure the written agreements between the PIHPs and the subcontractors contain the pertinent information detailed in this provision.

438.236 PRACTICE GUIDELINES

Evidence indicated that adopting and implementing practice guidelines is new to the majority of the PIHPs. A number of the practice guidelines adopted were developed locally and did not appear to be based on valid and reliable clinical evidence. Often Network Providers were unaware that practice guidelines had been adopted, and if they did know, they couldn't remember what they were. Few PIHPs were able to demonstrate that the practice guidelines were being applied to utilization management decisions, enrollee education, type of service and fit and other pertinent decisions and interventions. As the behavioral health field is being asked to prove it is accountable and offers a valuable service for the expended resources, there is a lot more work being done to research and identify practice guidelines and evidence-based practices and their value to service recipients and the field. It is the recommendation of the EQRO that the PIHPs utilize the available research and research based practice guidelines when adopting guidelines for their regional system of care. It is also recommended to include enrollees and Network Providers in the development and decision making processes related to the adoption of practice guidelines. Once the practice guidelines are officially adopted, it would be helpful for the PIHPs to provide a formal, in-depth training for the Provider Networks and interested consumers with particular focus on the application of the practice guidelines.

SUBPART C ENROLLEE RIGHTS AND PROTECTIONS

PIHPs areas of strength include:

- Throughout the State during interviews with the PIHP and Network Provider staff there was an inherent commitment to the protection of enrollee rights and enrollees' privilege to freely exercise their rights.
- The PIHPs have included language in their Network Provider contracts requiring the providers to ensure that clients understand their rights.
- Compliance with other Federal and State laws is addressed in the PIHPs' policies and clearly included in their subcontracts with their Network Providers.
- Policies and procedures that ensure against prohibiting or otherwise restricting any subcontractor from advising or advocating on behalf of an enrollee who is his or her patient with regard to: (i) the enrollees health status, medical care, treatment options and alternative treatment options that may be self administered; (ii) any information the enrollee needs in order to decide among all relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions were in place throughout all the PIHPs across the State.
- The PIHPs have conveyed to the Network Providers via their contract that they are required to maintain Mental Health Advance Directive policies and procedures.

PIHPs opportunities for improvement:

- The PIHPs must ensure Network Providers post enrollee rights in public places in all identified prevalent languages for their region.
- Establish specific policies and procedures on how the PIHPs monitor their subcontractors to ensure compliance with other Federal and State laws (i.e. Title VI of the Civil Rights Act of 1964; Titles II and III of the Americans with Disabilities Act, laws of privacy and confidentiality), as well as how the PIHPs monitor their subcontractors to ensure compliance with enrollee rights (i.e. right to a second opinion from a qualified health care professional within the network, at no cost to the enrollee; client involvement in decisions about their mental health treatment; client access to clinical records).
- All the PIHPs throughout the State must adequately ensure in their subcontracts with their Network Providers that Medicaid enrollees are not held liable for payment if the PIHP does not pay its subcontractors; or for covered services provided to the enrollee for which the State does not pay the PIHP; or for any service provided on referral that exceeds what the PIHP would cover if provided within the network; or for community psychiatric hospitals in the event of insolvency.

- All fourteen (14) PIHPs must ensure that their subcontracts clearly reinforce the requirement that all adult enrollees must be informed in writing about their right to be advised of the Mental Health Advance Directive and the policies associated with them as evidenced in their clinical record by the enrollees signed statement indicating their choice to put into effect an Advance Directive or not.

CFR Reference	State-wide Compliance Determination Report
438.10	Information Requirements The PIHPs are required to have written policies and procedures to ensure that all regulatory provisions of this CFR have been implemented, as well as have available the most recent Department of Social and Health Services (DSHS) Public Mental Health System Benefits Booklet in all seven (7) DSHS languages (Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese, and English) at the PIHPs and Network Providers for the enrollees. All fourteen (14) PIHPs had the Benefits Booklet available at the PIHP in all required languages. The Benefits Booklet was not available at all the interviewed Network Providers. Six (6) of the PIHPs also showed evidence of written policies and procedures ensuring that all the information requirements of this provision have been implemented demonstrating moderate to substantial compliance.
438.100(b)	Specific Enrollee Rights All fourteen (14) PIHPs showed evidence of written policies that guarantee the rights of the enrollees. Nine (9) of the PIHPs' policies included all the rights as specified in this CFR demonstrating moderate to substantial compliance. All fourteen (14) PIHPs have minimally referenced in their Network Provider contracts the requirement to advise enrollees of their rights in their primary language as needed. Seven (7) of the PIHPs demonstrated moderate to substantial compliance. The PIHPs are required to have contract language that holds subcontractors to posting their rights in public places in all prevalent languages. Only three (3) of the fourteen (14) PIHPs demonstrated moderate compliance with this provision. The PIHPs must have contract language in their Network Provider contracts that require subcontractors to ensure that the clients understand their rights. Six (6) of the fourteen (14) PIHPs showed evidence of moderate to maximum compliance.

438.100(c)	Free Exercise of rights This requires the PIHPs to have contract language that holds subcontractors to the protection of the enrollee's right to exercise his or her rights and that when enrollees exercise these rights, there is stated assurance that their treatment will not be adversely affected. All fourteen (14) PIHPs provided evidence showing that this provision is minimally referenced in their contracts with their Network Providers. Nine (9) of the fourteen (14) PIHPs demonstrated moderate to maximum compliance.
438.100(d)	Compliance with Other Federal and State laws The provision requires the PIHPs to comply with other Federal and State laws as reflected in their policies and ensure that Network Providers comply with other Federal and State laws as evidenced by language in the PIHPs' Network Providers contracts. All fourteen (14) PIHPs at least partially referenced compliance with other Federal and State laws in their policies and eight (8) PIHPs demonstrated moderate to substantial compliance. In addition, all the PIHPs at least minimally address the requirement of Network Providers complying with other Federal and State laws in their contracts and twelve (12) PIHPs showed moderate to maximum compliance. Under this section the State requires the PIHPs to have policies and language in their Network Provider contracts to ensure compliance with the right to a second opinion from a qualified health care professional with the network at no cost to the enrollee, client involvement in decisions about their mental health treatment and client access to clinical records. All fourteen (14) PIHPs at least minimally addressed compliance with these three (3) client rights in their policies and Network Provider contracts. Six (6) PIHPs demonstrated moderate to substantial compliance with regard to their policies addressing these three (3) client rights. Seven (7) of the PIHPs exhibited moderate to maximum compliance with ensuring a right to a second opinion, client involvement in treatment decisions and client access to clinical records in their Network Provider contracts. In addition, the PIHPs are required to have policies and procedures on how they monitor their subcontractors to ensure compliance with these regulations. All the PIHPs at least minimally address how they monitor their subcontractors to ensure compliance with these regulations, however, four (4) of the fourteen (14) PIHPs were able to demonstrate moderate to maximum compliance.
438.102	Provider-Enrollee Communications This requires the PIHPs have policies and procedures that ensure

	against prohibiting or otherwise restricting any subcontractor from advising or advocating on behalf of an enrollee who is his or her patient in respect to the specific regulatory provisions of this CFR. All fourteen (14) PIHPs at least partially addressed the required provisions in their policies and procedures and or Network Provider contracts. Eleven (11) of the fourteen (14) PIHPs showed evidence indicating moderate to maximum compliance.
438.106	Liability for Payment This requires the PIHPs Network Provider contracts contain language that ensures enrollees are not charged or held liable for payment related to: (a) covered services provided to the enrollee for which the State does not pay the PIHP; or (b) any service provided on referral that exceeds what the PIHP would cover if provided within the Network; community psychiatric hospitals in the event of insolvency, or nonpayment to the PIHP Network Provider. All but one (1) of the fourteen (14) PIHPs at least partially addressed these regulatory provisions in their Network Provider contracts and four (4) PIHPs demonstrated moderate compliance.
438.10(g) 438.6(l)	Advance Directives The PIHPs are required to have written policies and procedures for the Mental Health Advance Directive and they also must specify in their subcontracts that their Network Providers must have Mental Health Advance Directive policies and procedures. All fourteen (14) PIHPs at least minimally addressed both of these requirements. Nine (9) of the PIHPs demonstrated moderate to substantial compliance with requiring Network Providers to have Mental Health Advance Directives policies and procedures. The PIHPs are also required to ensure that their policies reflect changes in State law as soon as possible but no later than ninety (90) days after the effective date of the change. All but one (1) of the PIHPs presented a procedure that at least minimally addressed this provision and seven (7) of the PIHPs showed moderate to substantial compliance. Additionally the PIHPs subcontracts are to clearly reinforce the requirement that all adult enrollees must be informed in writing about their right to be advised of the Mental Health Advance Directive and associated policies as evidenced in their clinical record by a signed statement indicating their choice for a Mental Health Advance Directive or not. All but two (2) PIHPs minimally addressed this provision in their subcontracts and four (4) of the fourteen (14) PIHPs achieved moderate to substantial compliance.

SUBPART D QUALTIY ASSESSMENT AND PERFORMANCE IMPROVEMENT

PIHPs areas of strength include:

- The PIHPs were organized and well prepared for the external quality review demonstrating a commitment to the process of the review and continuous quality improvement.
- The PIHPs have well established, positive and effective working relationships with their Network Providers throughout their regions. Network Providers expressed value in the PIHPs attitude of partnership and inclusive decision making processes that are generally practiced by the PIHPs.
- Comprehensive set of HIPAA policies and procedures have been developed and implemented by the majority of the PIHPs across the State, as well as clearly outlining contract compliance with these requirements in their subcontracts with their Network Providers.
- The PIHPs promote the delivery of culturally competent services by ensuring the availability and use of Mental Health Specialists.
- Policies and procedures as well as effective mechanisms are employed by the PIHPs to ensure they do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.
- The PIHPs have specifically delineated the State standards for timely access in their subcontracts with their Network Providers.
- Well defined expectations and standards of what the PIHPs expect to be included in the treatment plan emphasizing the importance of reflecting the enrollee's expressed treatment goals and preferences.

PIHPs opportunities for improvement:

- Translation of enrollee rights, grievance systems and other enrollee materials into the seven (7) prevalent languages as determined by the Department of Social and Health Services.
- Develop and implement policies regarding the use of out of network providers and procedures to support coordination with respect to payment.
- Immediately establish a process to track denials of medical necessity and institute Notice of Actions in order to protect and allow enrollees the opportunity to exercise their right to appeal.
- All fourteen (14) PIHPs must develop effective policies and procedures for standard and expedited authorization decisions including procedures for extension of expedited authorization decisions.
- Design and establish sufficient controls as part of the authorization and utilization management functions in order to prevent and detect under and over utilization and managed care fraud and abuse (intentional and/or unintentional), particularly when the Provider holds the financial risk.
- When delegating PIHP responsibilities, before any delegation, each PIHP must evaluate the prospective subcontractor's ability to perform the activities to be delegated. PIHPs should develop a formal delegation plan

with each subcontractor when delegating PIHP functions to that subcontractor. The Delegation plan should include a written agreement which specifies the activities and reports responsibilities delegated to the subcontractor; delineates the annual review process associated with the delegated functions including the process for corrective actions, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

- The PIHPs need to clarify responsibility for developing and adopting practice guidelines and ensure two (2) new practice guidelines are adopted for this coming year. Consider and incorporate enrollees' needs into current and subsequent practice guidelines and ensure application of practice guidelines to utilization management decisions, enrollee education, coverage of services and other areas to which the guidelines apply.

CFR Reference	State-wide Compliance Determination Report
438.206 (b)(1)	<u>Availability of Services</u> This regulation requires the PIHPs to have mechanisms in place that monitor their Provider Networks on a reasonable basis to ensure adequate access to all medically necessary services based on: (i) The anticipated Medicaid enrollment; (ii) The expected utilization of services, considering Medicaid enrollee characteristics and health care needs; (iii) The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services; (iv) The number of network providers who are not accepting new Medicaid patients; and (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities. All fourteen (14) PIHPs at least presented minimal evidence indicating utilization of mechanisms to monitor their Provider Networks to ensure adequate access to all medically necessary services. Ten (10) of the PIHPs exhibited moderate to maximum compliance. In Addition, the PIHPs are required to have mechanisms to monitor change in Provider Network sufficiency and to provide reports to the State in a timely fashion, as well as ensure that Provider Networks remain adequate to provide all services by responding to changes in subcontractors and/or population served, including gaps in service capabilities. All the PIHPs with the exception of one (1) have at least minimal mechanisms to monitor and respond appropriately to change in their Provider Networks and provide reports to the State in a timely fashion. Ten (10) of the fourteen (14) PIHPs demonstrated moderate

	to maximum compliance.
438.206 (b)(3)	Delivery Network-Second Opinion This regulation requires the PIHPs to guarantee enrollees a second opinion and have mechanisms to ensure that this is accomplished in a systematic way and that the PIHP subcontractors clearly pass this requirement on to the Network Providers as part of their service delivery. All fourteen (14) PIHPs at least minimally demonstrated that they have mechanisms to ensure enrollees receive second opinions in a systematic way as part of the Provider Network service delivery. Four (4) of the PIHPs exhibited moderate to substantial compliance.
438.206 (b)(4-5)	Delivery Network-Out of Network Providers The PIHPs are required to have a policy that stipulates the PIHP will purchase services outside the Provider Network if no Provider within the Network is able to serve the enrollee and has a system to ensure that subcontractors are aware of the policy so that they make out of network referrals when necessary. Additionally, the PIHPs must have mechanisms in place to ensure that cost to enrollees when an out of network provider is used is no greater than it would be if the services were furnished within the network. All fourteen (14) PIHPs with the exception of two (2) at least minimally addressed access to out of network providers at no cost to enrollees in their policies. Only three (3) of the PIHPs demonstrated moderate to substantial compliance with these provisions. In addition, all but one (1) of the PIHPs at least minimally addressed in their policies the use of out of network providers and procedures to support coordination with respect to payment. Only two (2) of the PIHPs demonstrated moderate compliance.
438.206 (c)(1)	Furnishing of Services The PIHPs are required to ensure compliance with State standards regarding timely access to care and services as required in 438.206(c)(1)(i-vi). Additionally, each PIHP must specify the timely access standards and require compliance with the standards in their contracts with their Network Providers. All the PIHPs presented partial evidence at least of policies and procedures addressing their responsibility to ensure compliance with the State standards for timely access. Eleven (11) of the fourteen (14) PIHPs exhibited moderate to maximum compliance. In Addition, the PIHPs are required to have mechanisms for oversight of subcontractor compliance with standards for timely access. All PIHPs showed mechanisms of at least minimal compliance and eight (8) of the PIHPs demonstrated moderate to maximum compliance.

438.206 (c)(2)	Furnishing of Services Continued The State requirement to meet this regulation is that the PIHPs and their Provider Networks have consultations with Mental Health Specialists available to enrollees that meet the requirements defined and outlined in WAC 388-865-0150 and 0415. All PIHPs have at least partially addressed this requirement and twelve (12) of the PIHPs have exhibited moderate to maximum compliance by employing a substantial number of staff in a variety of specialist fields throughout their Provider Networks. Additionally, all fourteen (14) of the PIHPs demonstrated moderate to maximum compliance with regard to ensuring access to culturally competent service practices by requiring the use of Mental Health Specialists in their subcontracts with their Network Providers. In addition, this regulation requires the PIHP's and their Provider Networks to provide oral interpretation services for enrollees with limited English proficiency and/or are hearing impaired, and have available written materials in alternate formats in the seven (7) languages as called out by DSHS. All fourteen (14) PIHPs at least minimally addressed this requirement in their policies and procedures. Only two (2) PIHPs exhibited moderate to substantial compliance with this provision. The PIHPs are also required to ensure the availability of interpreters in the seven (7) DSHS languages when needed. All the PIHPs at least minimally addressed this requirement in their policies and procedures and eleven (11) PIHPs demonstrated moderate to substantial compliance. Finally, this provision requires The PIHPs to have mechanisms for oversight of culturally competent service standards. All fourteen (14) PIHPs presented at least minimal evidence of mechanisms that are utilized for oversight of culturally competent service standards. Ten (10) of the PIHPs exhibited moderate to substantial compliance.
438.207	Assurances of Adequate Capacity and Services This regulation requires the PIHPs to maintain a network of Community Mental Health Agencies (CMHAs) that are sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. All fourteen (14) PIHPs provided evidence demonstrating at least minimal mechanisms in place that are utilized to maintain a sufficient number and mix of Network Providers. Seven (7) PIHPs demonstrated moderate to maximum compliance in maintaining a sufficient network of CMHAs. In addition the State requires the PIHPs to submit documentation demonstrating compliance with offering an appropriate range of

	preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area at the time of the waiver renewal or when the changes are substantial or any time there has been a significant change (as defined by the State) in the operations of a PIHP that would affect adequate capacity and services including: (i) changes in PIHP services, benefits, geographic service area or payments or (ii) enrollment of a new population in the PIHP. Twelve (12) of the fourteen (14) PIHPs demonstrated moderate to maximum compliance with submitting State required documentation regarding substantial changes related to adequate capacity.
438.208(c)	MHD reported these requirements have been waived by CMS and therefore were determined to not be applicable.
438.210(b)	<u>Authorization of Services</u> To comply with this regulation the State requires that the PIHPs ensure authorizations of services occurs within the consistent application of the Access to Care Standards published by the Mental Health Division throughout the Provider Networks and in consultation with the requesting providers. All the PIHPs presented evidence indicating at least minimal compliance with the implementation of the Access to Care Standards. Five (5) of the PIHPs demonstrated moderate to substantial compliance. Additionally, all but one (1) PIHP showed at least minimal compliance with ensuring that authorization decisions are made by Mental Health Professionals, as defined in WAC 388-865-0150, with appropriate clinical expertise. Six (6) of the fourteen (14) PIHPs exhibited moderate to substantial compliance with this provision. Also the PIHPs are required to conduct audits of Network Providers that insure compliance as evidenced by clear policy at the agency level and consistent authorization practices. All fourteen (14) PIHPs with the exception of two (2) presented evidence indicating at least minimal audit mechanisms are in place to insure consistent authorization practices. Five (5) PIHPs demonstrated moderate to substantial compliance.
438.210(c)	<u>Notice of Adverse Action</u> This regulation requires the PIHPs to notify the requesting provider, and give the enrollee written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42CFR438.404, except that the notice to the provider need not be in writing. All fourteen (14) PIHPs at least minimally addressed the requirements associated with Notice of Actions in their grievance system policies and procedures. Only one (1) PIHP demonstrated moderate compliance. It is important to note

	that only one (1) PIHP had started the process of issuing Notices of Actions at the time of the external quality review.
438.210(d)	Timeframe for decisions This regulation requires the PIHPs to have policies and procedures that address the requirements associated with standard authorization decisions which include providing notice as expeditiously as the enrollee's health condition requires and within fourteen (14) calendar days of the request for service, with a possible extension of up to fourteen (14) additional calendar days. All fourteen (14) PIHPs with the exception of one (1) at least minimally addressed the requirements associated with standard authorization decisions in their policies and procedures. Only two (2) of the PIHPs demonstrated moderate to maximum compliance. Additionally, all fourteen (14) PIHPs with the exception of two (2) at least minimally addressed the requirements associated with expedited authorization decisions within their policies and procedures and three (3) PIHPs exhibited moderate compliance. Regarding extensions of expedited authorization decisions four (4) PIHPs did not include the required information in their policies and procedures and only one (1) PIHP demonstrated moderate compliance.
438.210(e)	Compensation for Utilization Management Activities This regulation requires each contract must provide that, consistent with 42 CFR 438.6(h), and 42 CFR 438.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. If the PIHPs contract with entities to perform ASO activities the PIHPs must have mechanisms in place that protect against financial incentives to authorize care in such a way as to minimize financial risk (or maximize financial gain). This regulation was not applicable to two (2) PIHPs. Three (3) of the PIHPs did not show evidence of mechanisms in place to provide for adequate controls to prevent financial incentives related to under and over utilization. Six (6) of the PIHPs presented evidence indicating minimal mechanisms of control in place and three (3) PIHPs demonstrated moderate compliance with this provision.
438.214(c)	Nondiscrimination The PIHPs are required to guard against discrimination of particular providers that serve high risk populations or specialize in conditions that require costly treatment. Twelve (12) of the PIHPs showed evidence indicating that this regulation was at least minimally addressed in their policies and procedures. Eight (8) of the PIHPs demonstrated moderate to substantial compliance.

438.12	Excluded Providers This regulation stipulates that PIHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. All the PIHPs partially addressed this requirement in their policies and procedures and twelve (12) of the fourteen (14) PIHPs demonstrated moderate to maximum compliance.
438.224	Confidentiality To comply with this regulation the State requires the PIHPs to have policies regarding compliance with 45 CFR parts 160 and 164, Subparts A and E (HIPAA) and that the PIHPs ensure that subcontractors comply with privacy requirements. All fourteen (14) PIHPs presented evidence via policies and procedures and contracts indicate at least minimal compliance with this regulation. Twelve (12) PIHPs exhibited moderate to maximum compliance. Additionally, The PIHPs are required to ensure through audits of their subcontractors that procedures are in place that protects privacy according to the provisions of 45 CFR. Five (5) PIHPs presented no evidence of privacy and confidentiality audits of their subcontractors in the past twelve (12) months. Three (3) PIHPs demonstrated at least minimal compliance and six (6) of the PIHPs exhibited moderate to maximum compliance.
438.230(b)	Sub-contractual Relationships and Delegation-Specific Conditions This regulation requires that before any delegation, each PIHP must evaluate the prospective subcontractor's ability to perform the activities to be delegated. Additionally, the PIHP must monitor the subcontractor's performance on an annual basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. Also, if the PIHP identifies deficiencies or areas of improvement, the PIHP and the subcontractor take corrective action. Thirteen (13) PIHPs presented evidence in their policies and procedures that indicated at least minimal compliance with these provisions. Three (3) of the PIHPs demonstrated moderate to maximum compliance. An additional requirement is that the PIHP must ensure there is a written agreement that: (i) specifies the activities and reports responsibilities delegated to the subcontractor; and (ii) provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. All the PIHPs but one (1) presented evidence in their policies and procedures that at least minimally addressed this provision. Three (3) of the fourteen (14) PIHPs exhibited moderate to maximum compliance.

438.236	Practice Guidelines This regulation requires the PIHPs adopt two (2) practice guidelines in the past twelve (12) months that are based on valid and reliable clinical evidence or a consensus of health care professionals, consider the needs of the enrollees, are adopted in consultation with contracting health care professionals and are reviewed and updated periodically as appropriate. All fourteen (14) of the PIHPs presented evidence indicating minimal efforts toward the adoption of practice guidelines. Only three (3) PIHPs demonstrated moderate to substantial compliance with the requirements associated with adopting practice guidelines. Additionally, three (3) PIHPs showed no evidence of dissemination of their adopted practice guidelines to affected providers and enrollees upon request. Seven (7) of the PIHPs at least minimally addressed dissemination of the practice guidelines in their policies and procedures and four (4) PIHPs demonstrated moderate to maximum compliance. The final requirement of this regulation is that the PIHPs must ensure the application of the practice guidelines. For example, decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. Five (5) PIHPs presented no evidence indicating they are actually applying the guidelines in practice. Nine (9) of the fourteen (14) PIHPs presented evidence that they are at least minimally applying their practice guidelines to services provided, enrollee education and the like.
438.240	Quality Assessment and Performance Improvement Program The reviewer requested all applicable evidence to support compliance with the requirements for this CFR. Frequently the items submitted included the following; ▪ PIHP Quality Management/Improvement Manuals ▪ PIHP Utilization Management Manuals ▪ Applicable items from the ISCA submitted by each PIHP ▪ PIHP Performance Measure Binders ▪ PIHP PIP Manuals ▪ Performance Measure and PIP Manual submitted by MHD The first requirement of this CFR was to find evidence that the PIHPs conduct performance improvement projects. These projects must achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that can be expected to have a favorable effect on health outcomes and enrollee satisfaction. All fourteen (14) PIHPs exhibited at least partial compliance with these requirements. Thirteen (13)

	PIHPs demonstrated moderate to maximum compliance. Another requirement of this CFR is that each PIHP must measure and report to the State its performance, using standard measures required by the State and submit to the State, data specified by the State that enables the State to measure the PIHP's performance. All fourteen (14) PIHPs showed evidence of at least minimal compliance. Five (5) of the PIHPs exhibited moderate to substantial compliance. This CFR requires also that the PIHPs must have in place mechanisms to detect both under utilization and over utilization of services. This item measures a core competency for health plans and should have a higher priority of focus but overall the PIHPs scored low. Most of the PIHPs ensure access to outpatient mental health services based upon the PIHPs' Level of Care Guidelines which incorporates the MHD Access to care standards. The PIHPs state they monitor over and under utilization by outpatient providers and inpatient facilities using utilization reports form their encounter data. It is sometimes unclear how the PIHPs utilize this data to assist them to control for over/under-utilization. The PIHPs for the most part have not been notifying the enrollee in the event of a denial of care. This is one mechanism that if in place, would protect against financial incentives to authorize in such a way as to minimize or maximize financial risk. This CRF requires that the PIHPs must have an ongoing program of Performance Improvement Projects (PIPs) that focus on clinical and non clinical areas and that involve the measurement of performance using objective quality indicators, implementation of systems interventions to achieve improvement in quality, evaluation of effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. The PIHPs and providers presented sufficient evidence that they are actively conducting the specific performance improvement projects that have been identified by the State. They have received the baseline results from the State regarding their performance on both the clinical as well as the data quality PIP. Both PIPs as currently designed have clear operational definitions, and a good description of the process to measure and report results. The PIHPs have demonstrated ability to facilitate a quality improvement process that can be expected to have a favorable effect on the health outcomes, enrollee satisfaction, and data quality. Since the PIP project is in the baseline year, they are not able to do an evaluation of effectiveness of interventions.
438.242	<u>Health Information Systems</u> Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter

	data system or other methods as may be specified by the State. All fourteen (14) of the PIHPs demonstrated compliance with this standard. The data systems employed captured all the data as specified by the State in their Data Dictionary for enrollees, provider characteristics and encounters. Ensure the data received from the providers is accurate and complete by verifying the accuracy and timeliness of the reported data. Seven (7) of the PIHPs reviewed scored a three (3) or greater on this item indicating moderate to maximum degree of compliance. Six (6) PIHPs scored a one (1) indicating they had the policy and/or procedure in place to score higher but the actual verification had not been taking place during the time period covered for this review. One (1) PIHP showed no compliance. Ensure the data received from the providers is accurate and complete by screening the data for completeness, logic and consistency and collecting service information in standardized formats to the extent feasible and appropriate. Six (6) of the PIHPs scored a three (3) or greater on this item indicating a moderate to maximum degree of compliance. While five (5) PIHPs scored a one (1) indicating they had the policy and/or procedure in place to score higher but actual checks had not been taking place during the period of time covered for this review. Three (3) PIHPs showed no compliance.

SUBPART F GRIEVANCE SYSTEM

PIHPs areas of strength include:

- All fourteen (14) PIHPs have updated grievance system policies and procedures that incorporate the majority of the regulations from the 438th chapter of the Code of Federal Regulations.
- The PIHPs are utilizing the Washington State Mental Health Division Grievance Template, the State developed grievance system description as an attachment to their Network Provider contracts.

PIHPs opportunities for improvement:

- Each PIHP must ensure that a description of the grievance system is posted in public areas accessible to enrollees in all identified prevalent languages for their region.
- Develop a grievance system that allows enrollees the opportunity to exercise their rights to appeal a denial based on medical necessity and clarifies the entity responsible for sending out Notice of Actions.
- Immediately implement the requirement and practice of issuing a Notice of Action when an action is determined.
- Provide extensive and ongoing training as needed to all Network Providers about recent changes to the PIHPs' regional grievance systems.

CFR Reference	State-wide Compliance Determination Report
438.402	Grievance System and Filing Requirements The PIHPs are required to have a system in place for enrollees that includes a grievance process, an appeal process and access to the State's fair hearing system and also includes the right for an enrollee or a Provider on behalf of the enrollee (with written consent) to file a grievance or an appeal. All fourteen (14) PIHPs have a grievance system in place that meets some or all of these regulatory provisions as indicated by their grievance system policies and procedures. Five (5) of the PIHPs demonstrated moderate to maximum compliance. Additionally, the PIHPs must include enrollee and Provider filing timeframes for grievances and appeals established by the State in their grievance system policies and procedures including the requirements that the enrollee or Provider must follow-up with a written signed grievance within ten (10) calendar days of filing an oral grievance and within seven (7) calendar days of filing an oral appeal. All the PIHPs with the exception of one (1) at least minimally addressed filing timeframes in their policies and procedures. Six (6) of the fourteen (14) PIHPs showed evidence of moderate to substantial compliance.

438.404	Notice of Action-Timing of Notice This regulation requires the PIHPs to include the Notice of Action time-frame provisions in their grievance system policy and procedures, including the timeframes associated with extensions. All fourteen (14) PIHPs at least minimally addressed the majority of the timeframes associated with Notice of Actions in their grievance system policies and procedures. Only one (1) of the fourteen (14) PIHPs demonstrated moderate compliance. It is important to note that only one (1) PIHP had started the process of issuing Notices of Actions at the time of the external quality review.
438.406	Handling of Grievances and Appeals Two (2) of the requirements of this regulation are: (1) the PIHPs must ensure enrollees are provided reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll free numbers that have adequate TTY/TTD interpreter capability, and (2) The PIHP must ensure that the individuals who make decisions on grievance and appeals are individuals who were not involved in any previous level of review, or decision-making or, if an appeal involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the State in treating the enrollee's condition. All the PIHPs at least minimally addressed these provisions in their grievance system policies. Eight (8) out of fourteen (14) PIHPs showed moderated to substantial compliance. Additionally, all fourteen (14) PIHPs were able to provide at least minimal evidence of established mechanisms to acknowledge receipt of each grievance and appeal within the State required timeframes. Six (6) of the PIHPs demonstrated moderate to compliance. All the PIHPs with the exception of two (2) at least minimally addressed each of the special requirements for handling appeals in 438.406(b)(1-4). Five (5) of the PIHPs showed evidence of moderate to maximum compliance.
438.408	Resolution and Notification of Grievances and Appeals The PIHPs are required to have mechanisms established for how they will dispose of each grievance and resolve each appeal. In addition, they must provide notice meeting the State's format requirements, expeditiously as the enrollee's health condition requires, within State established timeframes, including extension of timeframes and associated requirements. All fourteen (14) PIHPs were able to provide at least minimal evidence of established mechanisms to dispose of grievances and resolve appeals, as well as provide notice within the

	State established timeframes. Five (5) of the PIHPs demonstrated moderate compliance. In addition, the PIHPs are required to provide a written notice of the appeal resolution which includes the results of the resolution process and the date it was completed; the right to request a fair hearing and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action. All the PIHPs provided at least minimal evidence of compliance and six (6) of the fourteen (14) PIHPs demonstrated moderate to substantial compliance. Additionally, all fourteen (14) PIHPs at least minimally referenced the option of, and requirements for, State fair hearings including timeframes and description of the potential filing parties. Four (4) of the PIHPs showed evidence of moderate to substantial compliance.
438.410	Expedited Resolution of Appeals This regulation requires the PIHPs to have established mechanisms to ensure that an enrollee is afforded an expedited review process for appeals when the enrollee, Network Provider or PIHP determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. Additionally, the PIHPs must ensure that punitive action is neither taken against an enrollee or Network Provider who requests an expedited resolution or Network Provider who supports an enrollee's appeal. Each PIHP presented at least minimal evidence to having established mechanisms for an expedited review process and assurances that punitive actions will not be taken against the enrollee or their representatives. Five (5) of the fourteen (14) PIHPs demonstrated moderate compliance. Furthermore, all fourteen (14) PIHPs at least minimally referenced the specific actions required by this regulation to be implemented following a denial of a request for expedited resolution, including prompt oral notice of the denial to the enrollee within one (1) business day with a written notice to follow within two (2) calendar days and transfer of the appeal resolution. Six (6) of the PIHPs demonstrated moderate compliance.
438.414	Grievance Information to Network Providers and Agents of the PIHP This regulation requires the PIHPs to provide information about the grievance system as specified in 438.10(g)(1) to all subcontractors at the time they enter into contract using a State developed description. The PIHPs will utilize Exhibit P-Washington State Mental Health

	Division Grievance Template as an attachment to their Provider contracts. Each PIHP presented at least minimal evidence to utilizing Exhibit P or portions thereof. Ten (10) of the fourteen (14) PIHPs demonstrated moderate to substantial compliance.
438.416	Record Keeping and Reporting Requirements This regulation requires the PIHPs to have mechanisms to maintain records of grievances and appeals and mechanisms for reviewing grievances and appeals and creating quality improvements. All fourteen (14) PIHPs provided at least minimal evidence that they have record keeping and quality improvement mechanisms as part of their grievance system. Six (6) PIHPs demonstrated moderate to substantial compliance.
438.420	Continuation of Benefits while the PIHP Appeal and the State Fair Hearing are Pending The PIHPs are required to ensure the rights of enrollees as delineated in 438.420 are upheld during the time period an appeal or State fair hearing is pending. Each PIHP was able to present at least minimal evidence of compliance with this regulation and four (4) of the fourteen (14) PIHPs exhibited moderate compliance.
438.424	Effectuation of Reversed Appeal Resolutions This regulation requires the PIHPs to have mechanisms that ensure enrollee's rights are upheld regarding the authorization/provision of disputed services. All the PIHPs with the exception of one (1) presented at least minimal evidence of compliance and six (6) PIHPs demonstrated moderate compliance.

SUBPART H CERTIFICATIONS AND PROGRAM INTEGRITY

PIHP areas of strength include:

- The State has a standardized form for the PIHPs to use to certify their data transmissions.
- The systems used by both the State and the PIHPs have the capabilities in place to log the transmission and receipt of all the batches ensuring a one to one match on future certifications.

PIHPs opportunities for improvement:

- The EQRO reviews raised the understanding of this requirement to ensure the systems and records will be in place for these certifications to be fully compliant in the next review process.
- The PIHPs implementing new systems have an ideal opportunity to build the compliance requirement into the system processes while they are still defining the baseline procedures used to control their systems.

CFR Reference	State-wide Compliance Determination Report
438.606	Source content and timing of certifications This question required evidence of one (1) signed certification per batch transmitted on a standardized form and signed by an authorized individual (as specified in the rule). The forms used were defined by the State and had all the required elements. Eleven (11) of the fourteen (14) PIHPs scored four (4) or better for this item indicating substantial to maximum compliance. Three (3) of the PIHPs showed no compliance. With the requirement for these certifications to be a one to one match with the batches transmitted, it is incumbent on the State and the PIHPs to keep more accurate records on the batches transmitted and the certificates submitted. Each end of the system should be in a position to show evidence that this portion of the rule is followed. To this end, both the PIHPs and the State were not in a position to provide the reviewers a comprehensive set of records that both showed the batched transmitted by each PIHP and each certification collected and on file. The three (3) PIHPs that exhibited non compliance could be due to this lack of detailed record keeping.
438.608	Program Integrity Requirements This CFR requires that the PIHPs have a Fraud and Abuse Compliance Plan policy that articulates the PIHP's commitment to comply with all applicable Federal and State requirements, laws, regulations, including 42 Code of Federal Regulations (CFR) Part 438

	Subpart H, and applicable local laws and ordinances. The high score amongst the fourteen (14) PIHPs was four (4) with a low score of two (2). The PIHPs all have Fraud and Abuse Compliance Plans, evidence exists that they each have a designated Fraud and Abuse Compliance Officer and a Compliance Committee that are accountable to senior management. The Fraud and Abuse Compliance Plans include an education and training plan for PIHP employees and the commitment to notify Network Providers of applicable fraud and abuse training opportunities offered through the Centers for Medicare and Medicaid Services (CMS) or the State Mental Health Division. The PIHPs reported that they have previously participated in fraud and abuse trainings provided by CMS and the State Medicaid Fraud and Abuse Control Unit and have not found them to be helpful. Recommend that the PIHP continue to research opportunities for effective fraud and abuse training beyond what is provided by CMS and the State. The plans need to contain a comprehensive process of effective lines of communication between the Compliance Officer and the PIHP's employees. The Plans should clearly state to whom and how to report fraud and abuse, the investigation process, criminal activity, acts of retaliation, false accusations, anonymity and reporting back to the reporting individual. The opportunity here is that the PIHPs develop a mechanism for detecting Fraud and Abuse. No evidence of any internal monitoring and auditing specific for Fraud and Abuse was apparent throughout the majority of the PIHPs.
438.610	<u>Prohibited Affiliations with Individuals Debarred by Federal Agencies</u> This regulation states the PIHPs may not knowingly have a relationship with an individual who is debarred, suspended or otherwise excluded from participating in Federal Health Care programs under either section 1128 or section 1128A of the Social Security Act. The State requires PIHPs to perform background and debarment checks on employees and Network Provider leadership. All fourteen (14) PIHPs presented evidence indicating at least partial compliance and eleven (11) of the PIHPs exhibited moderate to maximum compliance with performing background and debarment checks.

Washington State External Quality Review
Performance Measure - Performance Improvement
And Performance Improvement Calculation Systems

PERFORMANCE MEASURE REPORT

Selected Performance Measures

Penetration Rates: Medicaid Population

The following issues were found causing this measure to be scored as Substantially Compliant at the time of the review:

1. Calculating the denominator: The denominator used in the calculation on these PMs is not based on Member Months but rather is calculated based on an unduplicated member year causing the population to be overstated. This not only creates an inaccurate weight for members that have been enrolled for only part of the year it causes members who have migrated among PIHPs through the year to be arbitrarily assigned to the denominator on one for the entire year.

2. There is a concern over the lack of control or assurance that data is submitted on each encounter. Since the method of remuneration statewide is largely based on sub capitation or case rates arrangements the inherent control requiring data submission in order to receive payment for services through the claims system does not exist. The lack of assurance is actually compounded by performance objectives associated with timely data submission in that late data is penalized so it provides a motivation to never submit encounter data after the deadline. Our review observed systems that created cut-off points prior to the deadline for timely data submission which resulted in data being under reported.

Outpatient Utilization: Medicaid Population Served

The following issues were found causing this measure to be scored as Not Valid at the time of the review:

1. In a small sample obtained from the field all clients and ninety-one percent (91%) of the encounters were found in the MHD-CIS system. The missing encounter data is possibly due in part to the system for reporting data submission errors to the PHIP having no feedback loop to assure that the data is cleaned up and re-submitted.

2. The encounter data submitted to the state lacks sufficient controls to assure that data for non-Medicaid enrollees or ineligible services are not included in the numerator.

3. There is a concern regarding the validity of the numerator because of a lack of control or assurance that data is submitted on each encounter. Since the method of remuneration statewide is largely based on sub capitation or case rates arrangements the inherent control requiring data submission in order to receive payment for services through the claims system does not exist. The lack of assurance is actually compounded by performance objectives associated with timely data submission in that late data is penalized so it provides a motivation to never submit encounter data after the deadline. Our review observed systems that created cut-off points prior to the deadline for timely data submission which resulted in data being under reported.

It should also be noted that because of the transition to HIPAA compliant transaction reporting (including associated software implementations) during 2004, and attempts by the PIHPs to ensure complete and accurate data is in place for the actuary study, the PIHPs encounter data has been delayed and inconsistent during the period reviewed by the EQRO as PIHPs correct and resubmit their encounter data. As a result of the EQRO's review and feedback, MHD reported they are currently investigating the source of under reporting observed by the EQRO.

The Surveys

The final two Performance Measures are both obtained from data collected from a statewide survey of participants that is conducted by the Washington Institute for Mental Illness and Training (WIMIRT). The Survey is done annually and targets adult participants one year and child participants on alternate years. The survey is designed to obtain objective unbiased information from persons receiving services through the publicly funded mental health care system.

The survey consists of open ended questions as well as items that were recommended by the Mental Health Statistical Improvement Project (MHSIP). Although the items selected do not appear to have been validated, the face validity of all items used in each Performance Measure is clear. No open ended questions were used in the Identified Performance Measures.

A sample for the Survey was drawn from the Mental Health Division's Management Information System. The target samples were selected immediately prior to the beginning of each survey. The population was stratified

into three (3) different age groups then a ten percent (10%) random sample was selected from each age group. The sample was designed to be representative of the State and to a lesser extent representative of each PIHP. Opportunities exist in selecting a sample that would be representative of at least some of the larger providers in each PIHP.

Youth and Parents' Perception of Quality and Appropriateness

The design and methodology used in obtaining this performance measure data, as well as the Adult Perception of Quality and Appropriateness data, rigorously followed a high standard of academic research both in the collection and analysis of the phases. Furthermore the preparation and dissemination of information was clear and timely making this a potentially useful tool in managing the related processes. There were adequate controls for validity, and reliability to be confident that this PM is valid.

Adults' Perception of Quality and Appropriateness

This measure was determined to be valid (see comments above).

PERFORMANCE IMPROVEMENT REPORT

Selected Performance Improvement Projects

Consumer Participation in Treatment

The State selected PIPs are scored as valid:

The processes used were evaluated and deemed to be functional and having appropriate controls for the data utilized in both numerator and denominator.

The Participation in Treatment Performance Improvement Project is based on a questionnaire sent to a representative sample of enrollees who have utilized services. The processes used by the states contractor to create and validate the sample, collect the data, analyze and report the results has used rigorous and acceptable controls to achieve a result that can be used to draw inferences about the target population with acceptable levels of confidence. We further reviewed the handling of the data containing PHI. This data is loaded and run on two separate machines. The primary machine that does the processing is isolated from a network and not a risk but there is another machine that holds the data while it is collected and collated (if you will) that is on a network intermixed with other machines that do not hold PHI. This machine should be segregated from those machines via a firewall to be HIPAA compliant.

Submission of HIPAA-Compliant Transactions

The process used to track this measures outcome is functional with ten (10) of the fourteen (14) PIHPs were successful in meeting the goals of this performance improvement project.

The goal is that by July 2004, at least 50% of the HIPAA transactions will meet the 60-day reporting window. Although 29% of the PIHPs did not make this mark, the EQRO saw this standard as being set too low. Many quality organizations that are data driven choose a six sigma target – indicating a near perfect outcome. (Six sigma indicating a process that produces not more than 3.4 defects per million.) A mid to upper 90 percentile target may have been more meaningful for this measure.

PERFORMANCE INDICATOR CALCULATION SYSTEM REPORT

Performance Indicator areas of strength include:

- Complex sources of data are merged and made comprehensive repeatedly in an environment of ever changing data
- The SAS code used is effective and well constructed
- The group responsible for this data evaluation process has profound understanding of the data and environment they work with within

Performance Indicator opportunities for improvement:

- The system processes employed need to be documented
- The data used needs to be archived
- The membership data needs to be more consistent and stable
- HIPAA security concerns need to be addressed
- The system of performance indicator reporting in not timely enough to be useful for management purposes

Performance Indicator Calculation System

The performance indicator calculation system uses SAS to process data in flat files using SAS code programmed by the individuals who run the system. All data that is used for performance indicators that comes from the MHD-CIS is extracted using SAS's PROC SQL. It is password protected and only reads are done. Data is extracted, put into SAS data sets and stored on a dedicated SAS server. A limited set of analysts can access the "data warehouse" machine. Production data sets are kept on a separate virtual drive from analysts files.

Once the data is on the SAS server it is safeguarded by limiting access to the server. Analysts do not run SAS jobs which access the MHD-CIS database. Only one individual writes the data extraction code. This could change in the future but currently this acts as a barrier between analysts and source data.

The MHD IT group backs up the SAS server as part of their back up systems. Occasionally the performance indicator group requests a special back up if a critical juncture is at hand. Source code is also back up to local machines. Approximately every six (6) months one of the analyst makes an additional back up of key data files and source code to an off-site machine.

During development of data sets to be used in a performance measure a series of internal consistency checks and cross checks with external sources are done to ensure that data as accurate as possible. Once the system goes into routine use ("production") SAS logs are checked after each run. Also, analysts note inconsistent data and special quality runs are determined.

Approximately two years ago a major QA initiative was undertaken on outpatient data. Results in service utilization obtained from SAS were compared to the same numbers in the ad hoc data base. At the time it was decided that results within three percent (3%) would be acceptable. Results were almost always within this tolerance. The exceptions were found in recent months and attributed to differences in the time when the two systems are run; indeed they reported that the high variances disappeared over time.

In developing data sets, data is not purposefully rounded, truncated, edited or otherwise changed. For specific reports data are sometimes combined or recoded in order to create meaningful categories, but source data is not changed.

All data sets are regenerated weekly from the MHD data sources in order to minimize divergence or drift of data. For example, if a data element for 1995 is revised in the IT system that change is reflected within the SAS data set within a week.

Infrastructure programs are revised when problems are found or yearly when new variables must be defined to accept data for the new year. In those cases the major data sets are named for the calendar year. For example, SU2004 contains all service utilization data through 2004. In 2005 we will have SU2005 and it will have all service utilization through 2005 (including everything that was in SU2004).

Counts are compared from SAS runs with an ad hoc system, other counts from fiscal. When counts do not agree they work with them until they do or they understand why they should not agree.

SAS code:

The SAS code was evaluated and deemed to be correct in function and it did not put the data used at risk of being altered.

The code used to calculate numerators and denominators was found to be valid.

SAS process and systems:

The SAS processes lack documentation which makes the repeatability of the results reliant on the individual who currently generates them. The processes used to import the data, build the tables, create the reports and archive the system is not documented. The responsibilities are divided in this small group of individuals; the loss of any one of them would prove devastating to the system. The SAS group stated that they know they need to document their system but

the priority of doing it is never high enough and being a small group there is never enough time to do it. The work they do and the processes they employ are complex and detailed. Documenting the system is the only way to avoid serious trouble in the future.

The data used is not archived for a given report run which makes repeating the results impossible and running new algorithms on that data set impossible. The data from the Medicaid eligibility system (Medical Assistance Administration – MAA) is very dynamic. It is known to not settle down for as long as eighteen (18) months after the date the data represents. The MAA data is used to calculate the Medicaid enrolled population used in penetration and utilization rate measures. The SAS group states that they reload this data and the MHD-CIS data weekly in order to minimize divergence or drift of data. This translates into results that are always guaranteed to be different because the base data is different. The difference is variable as is the data. The data not being archived into a library precludes the possibility of running new algorithms on previous sets of data and comparing those results with previous statistics. It eliminates the baseline further complicating their work. A system of archiving the data used during the year should be implemented and incorporated into their processes.

The data used is not stable causing variance in results that are not reconcilable. This item is touched on in the previous paragraph. The MAA system is primarily responsible for this situation. The system used by MAA will be replaced as a result of a new contracted entity developing a new system for DSHS/MAA. The implementation of the new system is slated to go in phases with the parts that are now broken being replaced first. Unfortunately, this is not considered broken; MHD can expect to begin seeing new sources of data in three (3) to five (5) years. This is the only hope for a fix to this situation in the foreseeable future.

The data contains PHI and is loaded and run on machines at differing locations without the proper firewalls for security as required by HIPAA. The security of the data at the various locations it is processed at needs to be surveyed and any issues with security need to be addressed. Any PHI data being used in a non HIPAA secured environment needs to have special physical, administrative and electronic protections to isolate it from the non PHI data. Policy and procedures need to be documented, door and/or cabinets need to be locked and firewalls installed if not present. A password policy that is role or user based also needs to be defined.

The timeliness of the reporting cycle for the performance indicators needs to be improved to be more effective as a tool for management. The indicators should be available to be checked more frequently so that small subtle changes can be made to the system in a more timely manner. Depending on the measure, this would translate into measures being available on a weekly, monthly or quarterly basis. The EQRO understands some indicators are available on a quarterly bases, but the full report comes out yearly with data represented dating back a

year and a half in some cases. The EQRO recommends this be looked at to see where changes are possible.

Washington State
PIHP External Quality Review
Information Systems Capability Assessment Report

ISCA REVIEW SUMMARY

This summary report offers a compilation of the observations in the ISCA reports done for each of the PIHPs.

The Information Systems Capability Assessments (ISCA) for the State of Washington Prepaid Inpatient Health Plans (PIHP) was overshadowed by system changes driven by both Year 2000 compliance issues and coding change requirements driven by the Administrative Simplification portion of the Health Information Portability and Accountability Act of 1996 (HIPAA).

Of the fourteen (14) PIHPs reviewed, more than half, eight (8) had replaced their systems for Year 2000 compliance issues. Five (5) of the eight (8) organized into a collective for the purpose of leveraging their resources for this replacement process calling themselves the Washington State Rural Consortium (WSRC). Of the remaining three (3), two (2) moved independently to a system called Raintree and one (1) attempted to develop their own system in-house. The in-house development effort was abandoned and that PIHP joined the WSRC. As a late joiner they were not a part of the initial implementation and were slated to be installed after the review of their PIHP took place. The system they were running during the review was the system they are abandoning. In all, eight (8) of the fourteen (14) systems reviewed were newly implemented or in the process of being implemented during the review.

The reviews were conducted onsite at the PIHPs premises and included one site visit with a provider agency and two other interviews with provider agencies at the PIHP. The providers were selected at random. While onsite with the PIHP interviews were conducted, policies and procedures were reviewed and facilities were toured. From each PIHP a provider was asked to provide a set of records that included demographic information and encounter data for the twelve (12) months prior to our review for ten (10) individuals. This data was brought back to our office in Olympia where we collected the PIHP names, client names, unique client ID and date of birth to pass on to the Department of Social and Health Services Mental Health Division (DSHS/MHD or MHD) for them to query their system for the corresponding records. Each electronic record returned was compared with the physical data on hand to ensure the data was accurate and complete. A calculation of the service dates of the encounters and the submission dates were made to provide a report of timeliness. The records selected were at random and the evaluation uses simple descriptive statistics to analyze the data.

The EQRO had many discussions at the PIHPs about the use of a member database and the data available to them to enable creating one. Initially, the EQRO was told that the data offered from MHD was too inaccurate and untimely to be of any use. The EQRO was also told the data itself was unstable making it difficult to work with (i.e., the record layout would change from month to month making it impossible to automate or simplify importing it or using it). The EQRO felt that eligibility for all but a small percentage of clients could be checked automatically if they had a member database available to use. The PIHPs were reporting that they use the MHD web site or pay sources for one-to-one eligibility checks. As the reviews moved forward, the EQRO asked each PIHP what their experience was about this subject. The EQRO found that some of the PIHPs were using the data offered by MHD with good success. Many of what was told to the EQRO initially was simply not true or if it was true it was dated information and was no longer true. The EQRO recommends the PIHPs implement member databases for their systems. Additionally, the EQRO recommends that the PIHPs who are doing this successfully share their experiences and techniques to help other PIHPs make this work for them. The data offered by MHD is from the DSHS Medical Assistance Administration (MAA) Medicaid eligibility database. That system is being replaced so the data accuracy and timeliness will get better. But even now, the margin of error is manageable. This would ease workload by only having to check eligibility for only those clients where there is a question about what the database is telling them; instead of all the clients, as it is now.

The EQRO collected records from the field for one hundred and thirty one (131) individuals which included four thousand two hundred and thirty one (4231) encounters. The data returned by MHD-CIS had all one hundred and thirty one (131) individuals but matches were found for only three thousand eight hundred and forty seven (3847) encounters. The missing three hundred and eighty four (384) encounters were primarily in five (5) individuals who had their names returned by the MHD-CIS system but no related encounters. The data we had from the field on those five (5) individuals had three hundred and fifty nine (359) encounters that was not reflected in MHD-CIS system. There were an additional twenty five (25) encounters in the data the EQRO had collected from the field that were not in the data returned by the MHD-CIS. Those encounters were spread out randomly belonging to the other clients' records returned by MHD-CIS.

Summary of record review

- Encounters from the field 4231
- Encounters matched with MHD-CIS data 3847
- Encounters missing from the MHD-CIS data 384
- Percentage of encounters not in MHD-CIS data 9.07 = 384/4231
- Encounters belonging to 5 clients with no encounter data in MHD-CIS 359

- Remaining encounters matched to existing clients in MHD-CIS data 25

Note: It's possible the five (5) individuals who had a match in the MHD-CIS system are duplicate entries and their encounters are held in their active Client ID. Possible aberrations in the queries used to draw the data out of the MHD-CIS system could also account for the results. (For example, it was noted that only one (1) month of data was returned for one of the PIHPS and more than twelve (12) was returned on all the others. Unfortunately, this was noted too late in the process to request another query to correct this error.) More research should be done to uncover why nine percent (9%) of the encounters were not present in the sample from the MHD-CIS system.

Strengths

All PIHP's have electronic data systems that collect one hundred percent (100%) of the data required by the State.

The PIHPs and the State participate in the Data Completeness and Consistency Workgroup (DCCW) as well as the Information Systems Data Evaluation Committee (ISDEC). Participation by the PIHPs and the State on these two teams shows a healthy willingness to collaborate on these issues by all parties involved.

Some of the largest systems in Washington State's system are long-term systems that have stood the test of time. They are stable, well run and have adequately documented processes, policies and procedures to help them to continue to be that way into the future.

Many of the systems that needed to be replaced for Year 2000 and HIPAA compliance issues joined together to combine their efforts and resources in what is looking like a very successful venture (the Washington State Rural Consortium). This process has been very successful to date and has the support and momentum to help it continue in that direction. The next steps of this process are in the beginning stages and involve implementing clinical packages throughout the system of PIHPs that are participating in this project. If this next phase continues to be as successful as the process has been to date, it will serve as an excellent model for others both in and outside of Washington State.

Opportunities for Improvement

Data Checks – Sixty-four percent (64%) or nine (9) of the PIHPs have significant opportunities to improve in this area

> Most of the PIHPs reviewed could improve system controls to ensure the data they contain is accurate and complete. Information systems are great at collecting and maintaining data, but just like accounting systems, they need methods to audit them for quality and accuracy.
>
> Without these documented controls in place, the confidence in the information the databases contain is low. An organization cannot run for long on data they and others have a low degree of confidence in.
>
> It should be cautioned that checking the data by reporting on what the system holds can be deceiving. Although these types of controls should also be put in place, the only real way to ensure what you think the data represents is through primary verification.
>
> It should be noted that fifty-seven percent (57%) of the systems reviewed were so new during our reviews that a majority of them were still in the process of being implemented. This was found to be the primary reason for many of the systems to be lacking in evidence of validation of their data during the period covered by this review. It is imperative the system of controls on the data's accuracy and completeness be reinstituted at the soonest possible opportunity.

Error Tracking – Fifty percent (50%) or seven (7) of the PIHPs have significant opportunities to improve in this area

> There are two steps in this process; from the providers systems to the PIHP's systems and from the PIHP's systems to MHD's system. In both cases error detection and reporting processes are in place to ensure the data being received by the respective systems is within parameters. Error codes are sent back to the submitters indicating the error condition. The record in error must be corrected and resubmitted. The issue is that there is no system in place to track those records that generated errors to assure they are corrected and resubmitted.
>
> A system that is fee for service has a natural control to ensure any data not accepted is corrected and resubmitted. With the providers in this system being sub capitated, at the very minimum, there needs to be processes in place that are documented in policies and procedures to assure data submitted and rejected due to errors, is corrected and

resubmitted in a timely manner. The policies developed should set strict timelines with penalties for not resubmitting data within those timelines. If at all possible, the issue with subsequent errors in the MHD-CIS should be corrected. Ideally, this entire process would be automated in both steps mentioned to help make error handling and data submission as reliable and consistent as possible.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 – Fifty percent (50%) or seven (7) of the PIHPs had significant opportunities in the area of HIPAA compliance

HIPAA issues were uncovered that include physical data security, missing Business Associate agreements, lack of adequate password security to systems with Personal Health Information (PHI) and missing or inadequate policies and procedures. Since properly implemented HIPAA policies are tantamount to client privacy, these items were acted on by MHD immediately when notified by the EQRO during the course of the reviews.

The physical data security issues involved situations where County IT shops maintained control over servers with PHI data without providing adequate physical (firewall) separations between the PHI data and non PHI data portions of their networks.

The missing Business Associate agreements involved the same Counties where there should be a Business Associate agreement in place to allow the County IT staff to administer the data on those PHI servers. There was also a PHIP that had declared itself a clearinghouse and as such is now required to have Business Associate agreements with it providers.

The reviewers looked for systems to have some form of user or role based security that was documented. Situations were found where neither type of security existed including situations where the systems security was not documented.

One of the interviewed providers had missing HIPAA policies and procedures and where HIPAA policies and procedures were documented they were inadequate. This provider has a new IT manager who was aware of the shortfall and assured the reviewers they were working to remedy the situation.

Member Months – Forty-three percent (43%) or six (6) of the PIHPs had opportunities in this area but this was a system-wide finding of significant importance

It was noted by the reviewers that CMS has several questions in the performance measure protocol that requires the calculation of member months. Without calculating member months there is no way to accurately calculate member years. Methods of calculating the error rate introduced into the system by not calculating member months could be used but is not. Many of the systems employed by the PIHPs have the capability to calculate member months. The EQRO encourages the PIHPs to begin making these calculations. Member months are directly related to the denominators used in three (3) of their selected performance measures. Failure to properly track member months causes errors in the proper calculation of the denominators and as such adversely impacts the accuracy of both their internal and external reporting of penetration and utilization.

Reports – Forty-three percent (43%) or six (6) of the PIHPs had significant opportunities to create management reports to aid in the running of their systems

At the time of our reviews many of the newly replaced systems were completely lacking any of the reports necessary to manage a system. The prior systems employed by these PIHPs had reports of one degree or another that helped them ensure control of their systems. There were reports on data timeliness, accuracy and completeness. There were ways to print out client records so chart reviews could be accomplished. There were reports that helped them do their one hundred and eighty (180) day reviews and reports that helped them check the number of hours entered as encounters against the number of hours scheduled for those encounters. Without these reports, these systems are not yet whole. The PIHPs are aware of this. They state that the reports are on the way, unfortunately, without them the systems are missing an important part of their functionality.

MHD SYSTEM REVIEW REPORT

In addition to reviewing the data systems at the PIHPs; the EQRO reviewed the data collection side of the Mental Health Division's (MHD) system. This group, which is referred to as the MHD-CIS, is responsible for maintaining the data that is collected from the PIHPs and transmitting the data to CMS. The EQRO asked for an Appendix X to be submitted as we did for the PIHPs and we followed up with addition questions that were raised when those responses were reviewed.

This system was found to be stable and well run. Areas of system security, backup and recovery, data processes and procedures are well thought out and thoroughly documented.

The system has had major enhancements to enable it to process HIPAA compliant transactions. This involved adding a middle tier BizTalk server and a HIPAA accelerator plus the addition of C# (C Sharp) components for HIPAA transaction processing.

They report significant delays in implementing HIPAA and that at the time of their response, all the PIHPs had yet to finish implementing HIPAA standard Electronic Data Interchange (EDI) transactions.

When asked if MHD maintains PHI data on the same network with non-PHI data the response was that the MHD systems are protected by firewalls separating DSHS from the Internet and the rest of State government. If DSHS (and MHD in kind) is declared as a covered entity (under HIPAA an organization is a covered entity if they have been declared as a health plan, health care clearing house or health care provider who transmits any health information in electronic form in connection to a HIPAA transaction 45 CFR 160.103), then this is in compliance under the HIPAA rules. If they have been declared a Hybrid HIPAA entity (a hybrid entity is a covered entity whose business activities include both covered and non-covered functions 45 CFR 164.103), then this situation should be look at further to ensure the PHI is adequately protected.

MHD should institute a process where random samples of data which are held by the providers are compared to information held in the MHD-CIS system. The current actuary study to determine capitated rates has been a strong incentive in 2004. However, since the PIHPs often use a sub-capitated payment system, there are minimal incentives or controls to ensure all the data from the provider level is submitted to the State's system.

Along the same lines as above, a process or system should be implemented to provide some form of accountability for records rejected due to errors so they can be tracked to ensure that errors are resolved and resubmitted by the PIHPs.

Supporting Materials

The following is extracted directly from the ISCA Report, Interview Notes and I.T. Reviewers Assessment Tool

I. General Information

Washington State
Department of Social and Health Services
Mental Health Division
Greg Klein, Technical Lead
1115 Washington St.
P.O. Box 45320
Olympia, WA 98504-5320
(360) 902-0826
(360) 902-0809 FAX
klinega@dshs.wa.gov

Managed Care Model Type: N/A

Year Incorporated: N/A

Member Enrollment over the last 3 years:

INSURER	Year 1 – FY2003	Year 2 – FY2002	Year 3 – FY2001
Privately Insured			
Medicare			
Medicaid	1,004,260	1,016,719	1,057,970
Other			

This is the organizations first formal IS capability assessment.

II. Information Systems: Data Processing Procedures and Personnel

The system run by MHD (MHD-CIS) is the repository for all the PIHP's data collected for the State. Data is sent to the MHD-CIS system within 60 days of the close of the month that the service was provided. The State of Washington's Mental Health system data collection efforts are led by MHD and the MHD-CIS staff. The State's primary tools to communicate the data requirements to the PIHPs are the State's Data Dictionary and Trading Partner Agreements for HIPAA compliant encounter data.

The System
The System is a Microsoft SQL server holding the data in a relational database. The data is extracted into a flat file for analytical reporting purposes. The data is processed in SAS to create the analytical reports. The SAS system is distinct

and separate from the SQL system. Both databases are characterized as proprietary.

Programming and Software Maintenance

Programmers use Transact Sequel (TSQL), Visual Basic for Applications (VBA) and SAS to create Medicaid data extracts or analytical reports. Training is listed at one hundred (100) hours a year of on the job training. Turnover over the last three years is listed at twenty percent (20%) for 2002, sixteen percent (16%) for 2003 and fourteen percent (14%) for 2004.

When code is revised the code is commented on internally and the output file is renamed using the date as a part of the name.

Encounter reporting is via HIPAA standard EDI Transactions. HIPAA Trading Partner Agreements (TPAs) are developed through the Information System Data Evaluation Committee (ISDEC), chaired by MHD with representatives from all PIHPs. This group tracks EDI impacted changes. This is in conjunction with Data Group Meetings (MHD MIS and MHD Research Unit and program area experts) will determine necessary changes.

Data Backup, Recovery and Quality

Six (6) of seven (7) nights a week these are a daily processing of community and hospital data. After that data is posted to the production database either a full or differential backup is done depending on the day.

The database is backed up onto tape, input files are retained. The tape backups are transferred offsite.

The process is documented. The developers of the productions applications are assigned the responsibility on a scheduled rotating basis.

The backups are done after a days worth of posting, backups can be restored to that point. There is no transaction processor.

Veritas backup server is used for files and SQL Server backup is used for the databases.

Medicaid data corruption is checked for using internal checks on the data, reviewing reports of the data, and through fiscal reporting which checks the data from another perspective.

The controls used to assure all Medicaid claims data entered into the system are fully accounted for include checks to ensure the MMIS load counts match the input counts and through the system of PIHP batch error reporting.

Load counts matching input counts: Data is downloaded from the MAA system including a count of recipients within the file. Once they import the data into MHD's system during the monthly eligibility processing, they run a query to count the customers. If their system count matches MAA's count, processing continues, otherwise it fails and sends a message to developers.

Security

The data contains Protected Health Information (PHI) which is covered by HIPAA security and privacy rules.

MHD IT does not maintain physical files that contain PHI. Access is restricted to the enterprise servers behind locked doors. They restrict access to database objects and use read/select only interfaces and applications. Passwords protect servers and workstations. Files with PHI are encrypted when transferred from the file servers files and systems use auto logoff after preset intervals of time.

DSHS has well documented HIPAA policies and procedures to ensure the security and privacy of the data they are entrusted with that contains PHI.

Government colleagues, PIHPs and providers, State Hospital users and MHD headquarters staff all have access to the data maintained by MHD at some point along the process. This access is controlled when possible with read/select only access using MHD intranet applications, excel macros and a linked database server using controlled access specific to the group and/or user(s). Firewalls restricted by port and application (like FTP, HTTP) isolate the systems containing PHI from non PHI systems and the Internet.

III. Data Acquisition Capabilities

CLAIMS OR ENCOUNTER TYPES

MEDIUM	State Hospital	Comm. Hospital	CLIP	Resi-dential	MH Outpatient	Drug	Other
Claims/encounters submitted electronically	100%	100%		100%	100%		
Claims/encounters submitted on paper							
Services not submitted as claims or encounters			100%				
TOTAL	100%	100%	100%	100%	100%	100%	100%

The following data fields are required by the PIHP for providers. An 'R' indicates a required field. No entry indicates data that is not required.

Data Elements	State Hospital	Comm. Hospital	CLIP	Residential	MH Outpatient	Drug	Other (E&T)
Patient Gender	**R**	**R**	**R**	**R**	**R**		
Patient DOB/Age	**R**	**R**	**R**	**R**	**R**		
Diagnosis	**R**	**R**		**R**	**R**		
Procedure				**R**	**R**		
First Date of Service	**R**	**R**		**R**	**R**		
Last Date of Service	**R**	**R**		**R**	**R**		
Revenue Code		**R**					
Provider Specialty		**R**					

How many diagnoses and procedures are captured on each claim or encounter?

	Claim		**Encounter**	
	Diagnosis	Procedures	Diagnosis	Procedures
Inpatient Data	**N/A**	**N/A**	**4**	**N/A**
Outpatient Data	**N/A**	**N/A**	**4**	**1**

Separate data fields in the database store principle and secondary diagnoses.

Inpatient Data: HIPAA 837I transaction for E&T Service error - reject transaction
HIPAA 837P transaction for Outpatient Service error - reject transaction

To verify the accuracy of submitted information for both inpatient and outpatient data the MHD-CIS contains base tables of the required data elements and their values that the data is compared against.

Medicaid encounter information can be changed by the PIHP and resubmitted to the MHD system. This generally happens when encounters kick back with errors and need to have corrections made to them before being resubmitted.

Specific examples are asked for where the contents of a field is intentionally different from the description or intended use of the field and the gender field is offered since it's default value is three (3), where one (1) = female and two (2) = male.

All of the data received by the MHD system is submitted via an intermediary, the PIHPs. They report that no data is changed that is submitted through the intermediary.

The coding scheme used is a combination of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes.

Modifications to their system are described as adding a middle tier BizTalk server and a HIPAA accelerator plus the addition of C# (C Sharp) components for HIPAA transaction processing.

They report significant delays in implementing HIPAA and that at the time of their response all the PIHPs had yet to finish implementing HIPAA standard EDI transactions.

They report ten (10) years of data online and that the data is available via the local Intranet and in applications used for that purpose.

All transactions are done via batch. They accept batches seven (7) days a week and they process batches five (5) days a week.

Completeness is unknown. They calculate if a submission is late by comparing service dates to submission dates. A status report is generated weekly that displays the timeliness of the PIHP submitted data including encounters.

Field edits are documented in the MHD-CIS Data dictionary. Diagnostic and procedure Codes are edited for validity and rejected when invalid.

When asked, if any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If yes, what were the results? They responded:

In the Research Group we have instituted Data Quality Graphs, which track by PIHP and State Plan Modality, the number of services being reported by month. These have been generated since July of 2004 and are shared with the Performance Data Group, and other stakeholders. We expect that these data will received more scrutiny as the emphasis on data continues through the EQRO work, rate setting and other initiatives that rely on these data. In addition, the research group is gathering all our data quality efforts into an organized effort to satisfy our requirement for an initial encounter validation to be completed for as one of our Waiver conditions by June 2005.

B. Enrollment System

Enrollment is based on Medicaid Eligibility and PIHP acceptance of non Medicaid individuals. The PIHPs' basically enroll a consumer when they supply the consumer's ID numbers (as known to the PIHP) and the consumer demographics. There have been no major changes in this portion of the MHD system.

There is only one product line and no disenrollment other than loss of Medicaid eligibility which may or may not disenroll the consumer from the PIHP.

The system can track consumers who may disenroll and re-enroll into Medicaid.

The system does not track consumers from one product line to another (they previously stated they only offer one product line.)

PIHPs report consumers across many providers so duplicates can occur but the PIHPs are responsible for removing duplicates. MHD's internal identifier changes when consumers are merged or new consumers are added with matching demographics.

When asked how can you identify and count member Medicaid member months and member years? They responded:

"Every month, MHD downloads a flat fixed-length file. MHD then imports that data into base tables in MHD-CIS. The base table format is based on the nature of the data captured (i.e., demographics, segment, TPL, etc). NOTE: each base table is refreshed every month - no history is preserved with MHD-CIS. All recipient history is contained within the monthly file from MAA. Each recipient is then run through processing that includes producing the PIHP-eligibility files. Each recipient is assigned a PIHP using the attributes within the base tables. The processing then extracts the recipients based on the assigned PIHP and produces several files for each PIHP each month."

As far as defining recipient months, the input file/base tables can contain up to twenty four (24) eligibility segments per recipient. Recipients can have one- (1)-to-many segments which can span one- (1)-to-many months. PIHPs receive all the available segments for the recipients assigned to that particular PIHP.

C. Ancillary Systems

Measure	Vendor Name
Penetration Rates: Medicaid Population	
Penetration Rates: State Hospital Inpatient per 1000 Population	
Youth and Parents' Perception of Quality and Appropriateness	
Adults' Perception of Quality and Appropriateness	

D. Integration and Control of Data for Performance Measure Reporting

Data on the SAS server is safeguarded by limiting access to the server. Analysts do not run SAS jobs which access the MHD-CIS database. Only one individual writes the data extraction code. This acts as a barrier between analysts and source data.

During development of data sets to be used in a performance measure a series of internal consistency checks and cross checks with external sources are done to ensure that data is as accurate as possible. Once the system goes into routine use ("production") SAS logs are checked after each run. Also, analysts note inconsistent data and special quality runs are determined.

In developing data sets, data is not purposefully rounded, truncated, edited or otherwise changed. For specific reports data are sometimes combined or recoded in order to create meaningful categories, but source data is not changed.

All data sets are regenerated weekly from the MHD data sources in order to minimize divergence or drift of data.

Counts are compared from SAS runs with an ad hoc system, other counts from fiscal. When counts do not agree they work with them until they do or they understand why they should not agree.

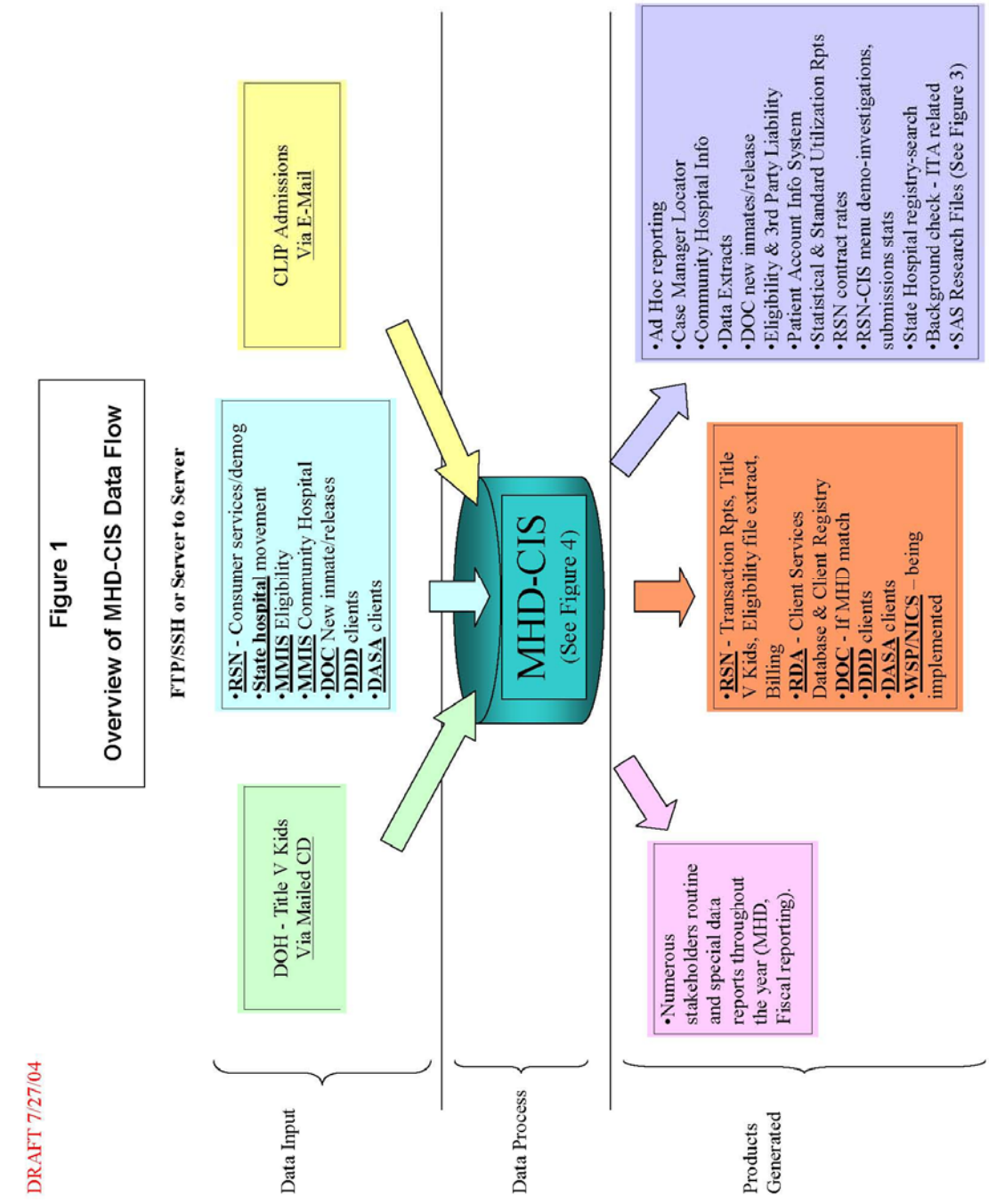


Figure 1
Overview of MHD-CIS Data Flow
DRAFT 7/27/04
FTP/SSH or Server to Server
Data Input
Data Process
Products Generated
DOH - Title V Kids Via Mailed CD
•RSN - Consumer services/demog
•State hospital movement
•MMIS Eligibility
•MMIS Community Hospital
•DOC New inmate/releases
•DDD clients
•DASA clients
CLIP Admissions Via E-Mail
MHD-CIS (See Figure 4)
•Numerous stakeholders routine and special data reports throughout the year (MHD, Fiscal reporting).
•RSN - Transaction Rpts, Title V Kids, Eligibility file extract, Billing
•RDA - Client Services Database & Client Registry
•DOC - If MHD match
•DDD clients
•DASA clients
•WSP/NICS – being implemented
•Ad Hoc reporting
•Case Manager Locator
•Community Hospital Info
•Data Extracts
•DOC new inmates/release
•Eligibility & 3rd Party Liability
•Patient Account Info System
•Statistical & Standard Utilization Rpts
•RSN contract rates
•RSN-CIS menu demo-investigations, submissions stats
•State Hospital registry-search
•Background check - ITA related
•SAS Research Files (See Figure 3)

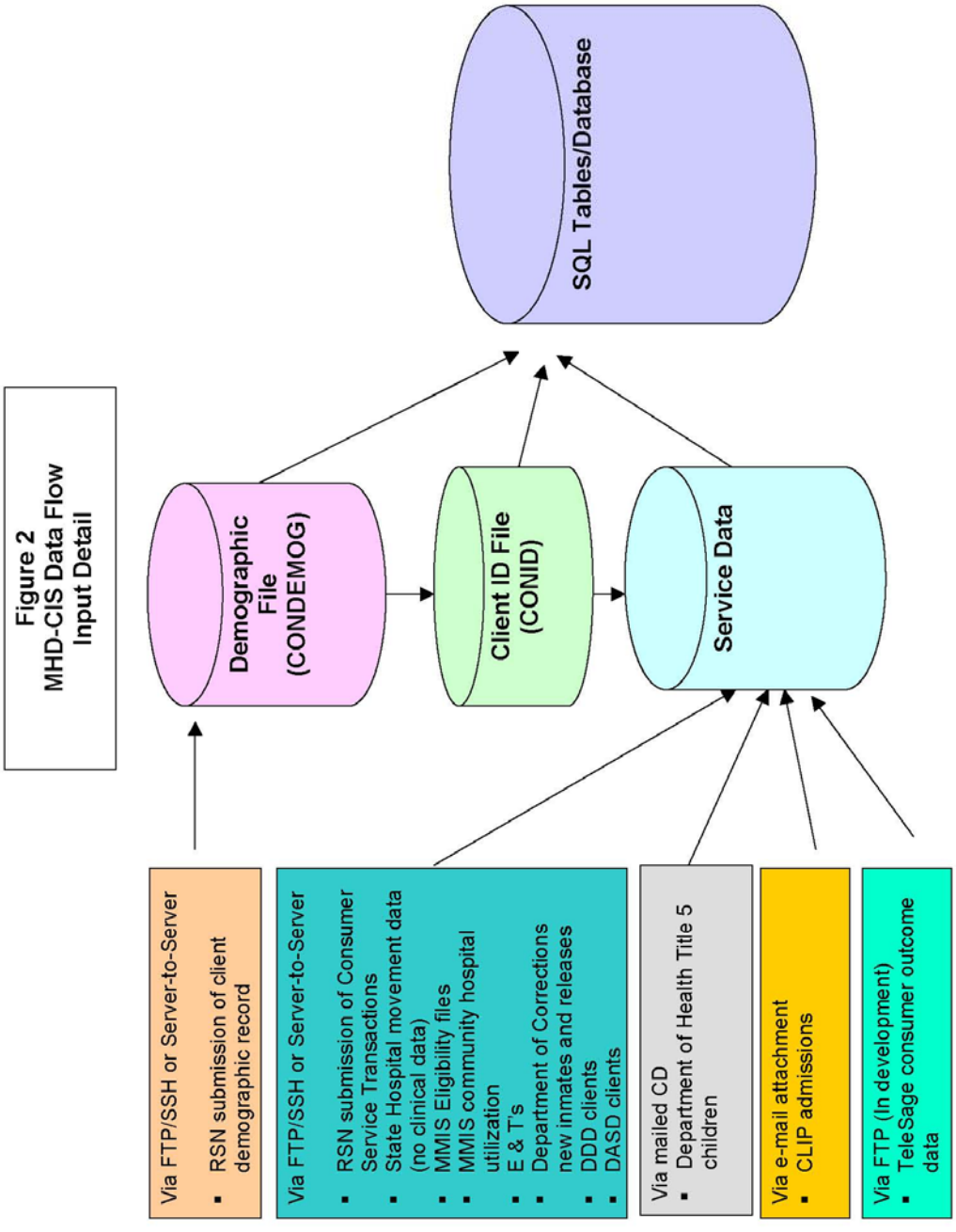


Figure 2
MHD-CIS Data Flow
Input Detail
SQL Tables/Database
Demographic File (CONDEMOG)
Client ID File (CONID)
Service Data
Via FTP/SSH or Server-to-Server
RSN submission of client demographic record
Via FTP/SSH or Server-to-Server
RSN submission of Consumer Service Transactions
State Hospital movement data (no clinical data)
MMIS Eligibility files
MMIS community hospital utilization
E & T's
Department of Corrections new inmates and releases
DDD clients
DASD clients
Via mailed CD
Department of Health Title 5 children
Via e-mail attachment
CLIP admissions
Via FTP (In development)
TeleSage consumer outcome data

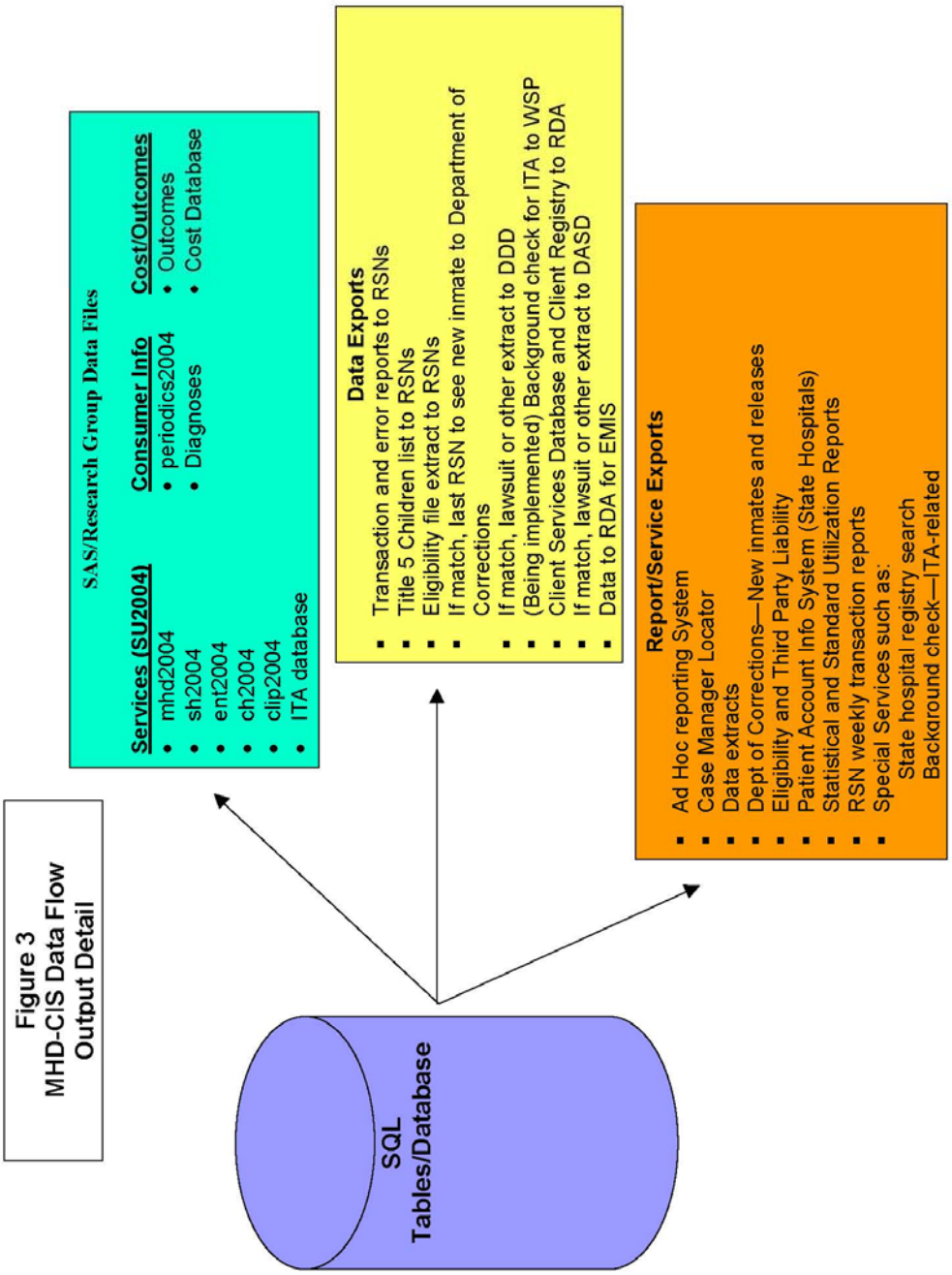


Figure 3
MHD-CIS Data Flow
Output Detail
SAS/Research Group Data Files
Services (SU2004)
mhd2004
sh2004
ent2004
ch2004
clip2004
ITA database
Consumer Info
periodics2004
Diagnoses
Cost/Outcomes
Outcomes
Cost Database
SQL
Tables/Database
Data Exports
Transaction and error reports to RSNs
Title 5 Children list to RSNs
Eligibility file extract to RSNs
If match, last RSN to see new inmate to Department of Corrections
If match, lawsuit or other extract to DDD
(Being implemented) Background check for ITA to WSP
Client Services Database and Client Registry to RDA
If match, lawsuit or other extract to DASD
Data to RDA for EMIS
Report/Service Exports
Ad Hoc reporting System
Case Manager Locator
Data extracts
Dept of Corrections—New inmates and releases
Eligibility and Third Party Liability
Patient Account Info System (State Hospitals)
Statistical and Standard Utilization Reports
RSN weekly transaction reports
Special Services such as:
State hospital registry search
Background check—ITA-related

Figure 4
MHD-CIS Detail